EOB / Adjustment Reason / Remark Codes

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0002	INVALID PATIENT RESPONSIBILITY	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N58	Missing/incomplete/invalid patient liability amount.	CO
0009	PROCEDURE REQUIRES INVOICE - ATTACHMENT RECEIVED	163	Claim/Service adjusted because the attachment referenced on the claim was not received.	M23	Missing invoice.	CO
0013	POSSIBLE MRWP DUPLICATE AGAINST HOSPICE, MENTAL HEALTH, COMMUNITY CA	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
0014	CODE INDICATING SUPERVISING PROFESSIONAL IS MISSING/INVALID	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M136	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.	CO
0015	CLAIM/DETAIL DETAIL DENIED. PROCEDURE IS LIMITED TO THE FOLLOWING	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0016	CLAIM/DETAIL DENIED. PROCEDURE IS LIMITED TO TRAUMA RELATED INJURIES.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0017	LONG TERM CARE DAYS BILLED IS GREATER THAN THE NUMBER OF DAYS IN BILLI	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA32	Missing/incomplete/invalid number of covered days during the billing period.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0018	CLAIM DENIED. ACCOMMODATION/ANCILLARY CODE MISSING OR INVALID.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M50	Missing/incomplete/invalid revenue code(s).	CO
0019	CLAIM/DETAIL DENIED. PROCEDURE/NDC MISSING/INVALID.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
0029	PROCEDURE REQUIRES ATTACHMENT	163	Claim/Service adjusted because the attachment referenced on the claim was not received.	N29	Missing documentation/orders/notes/summary/report/chart. (Modified 2/28/03, 8/1/05) Related to N225	CO
0030	UNITS OF SERVICE MISSING OR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M53	Missing/incomplete/invalid days or units of service.	CO
0044	MEMBER PLAN - PROCEDURE NOT BILLABLE WITH REVENUE	199	Revenue code and Procedure code do not match.	M67	Missing/incomplete/invalid other procedure code(s). (Modified 12/2/04) Related to N302	CO
0047	NEONATAL, EMERGENCY, CRITICAL CARE, CONSULT OR VISITATION PROCEDURE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
0050	COVERED DAYS ARE MISSING OR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA32	Missing/incomplete/invalid number of covered days during the billing period.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0051	PATIENT CONDITION/STATUS CODE MISSING, INVALID, OR INVALID FOR TYPE OF	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA43	Missing/incomplete/invalid patient status.	CO
0052	ERROR ON CLAIM RELATED TO DOLLAR AMOUNTS -CLAIM IN PROCESS	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO
0053	CLAIM/DENIED. NET BILLED NOT EQUAL TO TOTAL BILLED MINUS OTHER INSURAN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO
0056	PROCEDURE REQUIRES INVOICE BUT NONE RECEIVED	163	Claim/Service adjusted because the attachment referenced on the claim was not received.	M23	Missing invoice.	CO
0057	TYPE OF BILL INVALID FOR PROVIDER	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA30	Missing/incomplete/invalid type of bill.	CO
0059	HEADER NET CHARGE IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0062	THE HOUR OF ADMISSION IS MISSING OR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N46	Missing/incomplete/invalid admission hour.	CO
0087	VOIDED CLAIM FOR CHECK RETURN	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
0088	RECEIPT OFFSET CLAIM	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
0096	TREATING PROVIDER NOT ELIGIBLE FOR DATE OF SERVICE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95	This provider type/provider specialty may not bill this service.	CO
0099	INITIAL CYCLE OF CLAIM SUBMITTED BY DCH	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N512	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time without change to the adjudication.	CO
0101	DETAIL TO DATE OF SERVICE MISSING OR INVALID	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M59	Missing/incomplete/invalid 'to' date(s) of service.	CO
0104	TPL IS INDICATED ON FILE. BUT DID NOT APPEAR ON CLAIM. YOUR CLAIM WAS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N155	Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0107	REIMBURSEMENT RATE NOT FOUND FOR DATE OF SERVICE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
0110	INVALID COMBINATION OF PROCEDURES OR REVENUE CODES.	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	MA07	The claim information has also been forwarded to Medicaid for review.	CO
0118	ADMIT/DISCHARGE DATE CONFLICT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA40	Missing/incomplete/invalid admission date.	CO
0119	INVALID NEWBORN OCCURRENCE DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N299	Missing/incomplete/invalid occurrence date(s).	CO
0120	LAB PROCESSING CHARGE INCLUDED IN FLAT FEE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	OA
0121	MISSING PROVIDER NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N77	Missing/incomplete/invalid designated provider number.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0122	THIS SERVICE WAS NOT APPROVED BY MEDICARE. PLEASE RESUBMIT THIS SERVIC	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO
0124	THE DATE OF SERVICE IS MISSING OR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M52	Missing/incomplete/invalid 'from' date(s) of service.	CO
0125	THE TOOTH NUMBER IS MISSING OR INVALID	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N37	Missing/incomplete/invalid tooth number/letter.	CO
0126	ADMIT/DISCHARGE DATE CONFLICT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA40	Missing/incomplete/invalid admission date.	CO
0127	LAST DATE OF SERVICE AFTER DATE RECEIVED	110	Billing date predates service date.	M59	Missing/incomplete/invalid 'to' date(s) of service.	CO
0129	PROVIDER IS NOT ELIGIBLE TO SUBMIT FEE-FOR-SERVICE CLAIMS	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95	This provider type/provider specialty may not bill this service.	CO
0130	CLAIM/DETAIL DENIED. THE DAILY LIMITATION FOR THIS PROCEDURE CODE HAS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0132	TOTAL/SUBMITTED CHARGE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M54	Missing/incomplete/invalid total charges.	CO
0133	SUBMITTED CHARGES/TOTAL CLAIM CHARGE CONFLICT	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	M54	Missing/incomplete/invalid total charges.	CO
0136	REVENUE CODE IS MISSING/INVALID OR NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M50	Missing/incomplete/invalid revenue code(s).	CO
0138	TYPE OF BILL IS MISSING OR INVALID	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA30	Missing/incomplete/invalid type of bill.	CO
0141	HEADER TOTAL DAYS LESS THAN COVERED DAYS	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M53	Missing/incomplete/invalid days or units of service.	CO
0142	CLAIM EXCEEDS FILING LIMIT - REFER TO YOUR PROVIDER MANUAL FOR TIME LI	29	The time limit for filing has expired.	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0146	HCPC/REVENUE CODE MISSING. PROCEDURE CODE MISSING.	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M20	Missing/incomplete/invalid HCPCS.	CO
0149	THIS PROCEDURE/NDC IS NOT APPROPRIATE FOR THE MEMBERS AGE	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0150	THIS PROCEDURE IS INVALID FOR THE MEMBERS SEX	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
0151	THE NATIONAL DRUG CODE IS NOT VALID FOR THE DATES OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
0152	THE NATIONAL DRUG CODE IS NOT VALID	204	This service/equipment/drug is not covered under the patient&#65533;s current benefit plan	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
0153	PROCEDURE CODE INVALID FOR DIAGNOSIS CODE	11	The diagnosis is inconsistent with the procedure.	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
0155	RENDERING PROVIDER MUST HAVE AN INDIVIDUAL NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N290	Missing/incomplete/invalid rendering provider primary identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0163	DIAGNOSIS CODE MISSING OR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M76	Missing/incomplete/invalid diagnosis or condition.	CO
0165	INVALID HOSPICE UNITS FOR REV COD 0657	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M53	Missing/incomplete/invalid days or units of service.	CO
0167	PATIENT STATUS MISSING OR INVALID	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA43	Missing/incomplete/invalid patient status.	CO
0168	PRIMARY SURGICAL PROCEDURE CODE INVALID FOR MEMBERS SEX	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
0170	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. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M77	Missing/incomplete/invalid place of service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0172	PROCEDURE CODE INVALID OR MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
0173	ADMISSION DATE/FROM DATE OF SERVICE ARE NOT EQUAL	133	The disposition of this claim/service is pending further review.	M67	Missing/incomplete/invalid other procedure code(s). (Modified 12/2/04) Related to N302	PI
0175	PRIMARY SURGICAL PROCEDURE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
0179	TOOTH SURFACE/QUADRANT REQUIRED	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N37	Missing/incomplete/invalid tooth number/letter.	CO
0180	INVALID TOOTH NUMBER OR LETTER	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N37	Missing/incomplete/invalid tooth number/letter.	CO
0181	INVALID TOOTH SURFACE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N37	Missing/incomplete/invalid tooth number/letter.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0182	TOOTH NUMBER/LETTER REQUIRED	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N37	Missing/incomplete/invalid tooth number/letter.	CO
0184	TOTAL/SUBMITTED CHARGE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M54	Missing/incomplete/invalid total charges.	CO
0185	ADMISSION DATE MISSING OR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA40	Missing/incomplete/invalid admission date.	CO
0190	PRIMARY DIAGNOSIS CODE INVALID	147	Provider contracted/negotiated rate expired or not on file.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
0191	FDOS AND TDOS MUST EQUAL THE LAST DAY OF THE MONTH	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0193	MISSING DATE OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M52	Missing/incomplete/invalid 'from' date(s) of service.	CO
0194	DIAGNOSIS IS INVALID FOR MEMBERS SEX	10	The diagnosis is inconsistent with the patient's gender.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
0198	DOS SPAN MONTHS - FILE SEPARATE CLAIMS FOR EACH MONTH	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N61	Rebill services on separate claims.	CO
0204	ENCOUNTER MEMBER NUMBER MISSING OR INVALID	31	Claim denied as patient cannot be identified as our insured.	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO
0206	CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVI	185	The rendering provider is not eligible to perform the service billed.	N95	This provider type/provider specialty may not bill this service.	CO
0207	A SURGICAL PROCEDURE (WITHOUT A MODIFIER) IS BILLED WITHIN THE FOLLOW-	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	OA
0208	THIS PROCEDURE IS NOT COVERED FOR THIS DIAGNOSIS	11	The diagnosis is inconsistent with the procedure.	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
0209	CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0210	CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW.	147	Provider contracted/negotiated rate expired or not on file.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
0211	CLAIM/DETAIL DENIED. THIRD DIAGNOSIS IS NOT ON FILE.	147	Provider contracted/negotiated rate expired or not on file.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
0212	DIAGNOSIS POINTER IS INVALID	147	Provider contracted/negotiated rate expired or not on file.	MA63	Missing/incomplete/invalid principal diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0213	THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIA	147	Provider contracted/negotiated rate expired or not on file.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
0214	CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW.	147	Provider contracted/negotiated rate expired or not on file.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
0215	CLAIM DENIED - AGE RESTRICTION FOR COVERED DIAGNOSIS	9	The diagnosis is inconsistent with the patient's age.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
0216	SERVICE DATE IS AFTER THE MEMBERS DATE OF DEATH	13	The date of death precedes the date of service.	N330	Missing/incomplete/invalid patient death date.	CO
0217	THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBERS AGE	9	The diagnosis is inconsistent with the patient's age.	M64	Missing/incomplete/invalid other diagnosis.	CO
0218	FOURTH DIAGNOSIS IS INVALID FOR MEMBERS SEX	10	The diagnosis is inconsistent with the patient's gender.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
0219	FOURTH HEADER DIAGNOSIS ON REVIEW	147	Provider contracted/negotiated rate expired or not on file.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
0221	NONBILLING PROVIDER SUSPENDED - TERMINATED FOR PROGRAM BILLED	160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion.	N59	Please refer to your provider manual for additional program and provider information.	CO
0223	THE FROM AND TO DATES OF SERVICE MUST BE WITHIN THE SAME MONTH AND YEA	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO
0224	OCCUR DATE < HDR FDOS OR > HDR TDOS	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N299	Missing/incomplete/invalid occurrence date(s).	CO
0225	NO HISTORY MATCH FOUND, PLEASE RESUBMIT	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	N517	Resubmit a new claim with the requested information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0226	INVALID CONDITION CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
0228	CLINIC PROVIDER NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N278	Missing/incomplete/invalid other payer service facility provider identifier.	CO
0229	PROVIDER NUMBER INVALID OR MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N290	Missing/incomplete/invalid rendering provider primary identifier.	CO
0230	THERAPY NOT COVERED FOR MEMBERS AGE	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0232	ENCOUNTER UNITS OF SERVICE MISSING	38	Services not provided or authorized by designated (network/primary care) providers.	M53	Missing/incomplete/invalid days or units of service.	CO
0235	SURGERY DATE IS BEFORE THE ADMIT DATE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N341	Missing/incomplete/invalid surgery date.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0236	SURGERY DATE CANNOT BE OUTSIDE HEADER DATES OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
0238	MEMBER NAME IS MISSING OR FORMAT IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA36	Missing/incomplete/invalid patient name.	CO
0239	DETAIL PROVIDER NUMBER INVALID OR NOT ON FILE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N77	Missing/incomplete/invalid designated provider number.	CO
0240	PROCEDURE CANNOT BE BILLED INDEPENDENTLY	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N390	This service cannot be billed separately.	CO
0241	PENDING CONFIRMATION OF PROVIDER ELIGIBILITY	185	The rendering provider is not eligible to perform the service billed.	N95	This provider type/provider specialty may not bill this service.	CO
0242	NO PRICING SEGMENT FOR PROCEDURE/MODIFIER COMBINAT	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0245	MEMBER PLAN RESTRICTION FOR PROCEDURE COVERAGE RULE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
0248	CLAIM DENIED. SURGEON AND ASSISTANT SURGEON BILLING NOT ALLOWED ON SAM	54	Multiple physicians/assistants are not covered in this case.	N95	This provider type/provider specialty may not bill this service.	OA
0250	MEMBER NOT ON ELIGIBILITY FILE	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
0251	PA/PRECERT HEADER STATUS IS DENIED OR SUSPENDED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M62	Missing/incomplete/invalid treatment authorization code.	CO
0252	MEMBER NAME AND NUMBER DO NOT MATCH	140	Patient/Insured health identification number and name do not match.	MA36	Missing/incomplete/invalid patient name.	CO
0253	MEMBER INELIGIBLE FOR DETAIL DOS. WILL PEND FOR 14 DAYS AWAITING DCH U	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
0254	MEMBER INELIGIBLE ON DOS FOR HDR - DTL OR PARTIAL	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30	Patient ineligible for this service.	CO
0257	ENCOUNTER TOTAL BILLED AMOUNT INVALID - HEADER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0259	DATE BILLED INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO
0260	SERVICE NOT ALLOWED	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N431	Service is not covered with this procedure.	CO
0262	MEMBER NOT ELIGIBLE FOR DETAIL DOS	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
0263	MEMBER NOT ELIGIBLE FOR HEADER DATE OF SERVICE	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
0267	ENCOUNTER TOTAL BILLED AMOUNT INVALID - DETAIL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
0271	MEMBER APPLIED INCOME NOT CURRENT FOR DOS	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N30	Patient ineligible for this service.	CO
0273	MEMBER IS UNDER MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0274	DATE OF BIRTH ON CLAIM DOES NOT MATCH DOB ON MEMBER FILE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N329	Missing/incomplete/invalid patient birth date.	CO
0276	BENEFIT PLAN RESTRICTION FOR COVERED DIAGNOSIS	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
0278	CLAIM DENIED. CLAIM/DOCUMENTATION INDICATES THIRD PARTY PAYMENT WAS RE	100	Payment made to patient/insured/responsible party.	MA92	Missing plan information for other insurance. (Modified 2/1/04) Related to N245	OA
0279	ALIEN - CLAIM REQUIRES MEDICAL REVIEW. IF YOU DID NOT ATTACH MEDICAL T	133	The disposition of this claim/service is pending further review.	N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	PI
0280	CLAIM INDICATES THIS SERVICE IS DUE TO A WORK-RELATED ACCIDENT/INJURY.	19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	OA
0281	ABORTION PROC OR CONDITION CODE A7 OR A8 IS PRESENT AND NO ABORTION CE	197	Payment adjusted for absence of precertification/ authorization.	N29	Missing documentation/orders/notes/summary/report/chart. (Modified 2/28/03, 8/1/05) Related to N225	CO
0282	OUR RECORDS INDICATE MEMBER HAS MEDICARE PART A PLEASE BILL MEDICARE	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO
0283	OUR RECORDS INDICATE MEMBER HAS MEDICARE PART B: PLEASE BILL MEDICARE	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO
0284	OUR RECORDS INDICATE THAT THIS MEMBER IS ELIGIBLE FOR HOSPICE COVERAGE	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO
0285	MEMBER INELIGIBLE FOR DOS	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0286	THIS PROCEDURE CODE IS LIMITED TO ONE UNIT OF SERVICE PER DATE OF SERV	222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
0287	PROFESSIONAL COMPONENT REV CODE MUST BE BILLED WITH CORRESPONDING TECH	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	M66	Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate li	CO
0288	PROFESSIONAL COMPONENT REV CODE MUST BE BILLED WITH CORRESPONDING TECH	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	M66	Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate li	CO
0289	CLAIM DENIED. RENDERING PROVIDER NUMBER MISSING OR INVALID.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N77	Missing/incomplete/invalid designated provider number.	CO
0290	PENDING CONFIRMATION OF MEMBER ELIGIBILITY	133	The disposition of this claim/service is pending further review.	N30	Patient ineligible for this service.	PI
0291	PENDING POSSIBLE OTHER INSURANCE INVOLVEMENT	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N245	Incomplete/invalid plan information for other insurance	CO
0292	CLAIM SUSPENDED FOR BUY-IN ELIGIBILITY REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
0293	CLAIM SUSPENDED FOR ELIGIBILITY REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
0295	RENDERING OR REFERRING PROVIDER NUMBER IS MISSING	38	Services not provided or authorized by designated (network/primary care) providers.	N290	Missing/incomplete/invalid rendering provider primary identifier.	CO
0296	RENDERING PROVIDER NOT ENROLLED FOR COS	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N290	Missing/incomplete/invalid rendering provider primary identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0297	PROVIDER GROUP NUMBER INVALID FOR TREATING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO
0298	MEMBER IS NOT ELIGIBLE FOR HOSPICE FOR BILLED DATES OF SERVICE	204	This service/equipment/drug is not covered under the patient's current benefit plan	N30	Patient ineligible for this service.	CO
0299	HOSPICE MEMBER. OUR FILES SHOW MEMBER IS COVERED BY ANOTHER HOSPICE PR	B9	Services not covered because the patient is enrolled in a Hospice.	MA25	A patient may not elect to change a hospice provider more than once in a benefit period.	CO
0300	RENDERING PROVIDER ID NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N290	Missing/incomplete/invalid rendering provider primary identifier.	CO
0302	OTHER - 2ND PROVIDER ID NOT ON FILE - HDR	185	The rendering provider is not eligible to perform the service billed.	N521	Mismatch between the submitted provider information and the provider information stored in our system.	CO
0303	SERVICE MUST BE BILLED FOR A MINIMUM OF 8 UNITS PER DATE OF SERVICE	150	Payment adjusted because the payer deems the information submitted does not support this level of service.	M53	Missing/incomplete/invalid days or units of service.	CO
0305	TREATING PROVIDERS CLAIM DENIED AFTER DEPT OF HEALTH AND REHAB SRVS RE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N109	This claim was chosen for complex review and was denied after reviewing the medical records.	CO
0306	ENCOUNTER FIRST DIAGNOSIS MISSING OR INVALID	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0307	THE PROCEDURE CODE CAN NOT BE SUBMITTED FOR RENDERING PROVIDERS CLIA	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA120	Missing/incomplete/invalid CLIA certification number.	CO
0308	ENCOUNTER DATE DISPENSED IS MISSING /INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N304	Missing/incomplete/invalid dispensed date.	CO
0309	RENDERING PROVIDER IS UNDER REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
0310	ENCOUNTER NDC MISSING/INVALID	38	Services not provided or authorized by designated (network/primary care) providers.	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
0311	ENCOUNTER DAYS SUPPLY MISSING/INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N378	Missing/incomplete/invalid prescription quantity.	CO
0312	REFERRING PRACTITIONER NAME (NUMBER) IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N286	Missing/incomplete/invalid referring provider primary identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0313	SPECIAL PROGRAM INDICATOR FIELD - ONLY VALID ENTRY IS (04) FOR FAMILY.	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
0314	SERVICE DATES CONFLICT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N351	Service date outside of the approved treatment plan service dates.	CO
0315	TPL ON CLAIM, NOT ON MEMBER FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N155	Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.	CO
0316	CLAIM/DETAIL PAID. CLAIMS HISTORY REFLECTS THE TOOTH NUMBER PREVIOUSLY	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.	OA
0317	DETAIL ACCOMMODATION UNITS TOTAL ARE NOT EQUAL	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	M53	Missing/incomplete/invalid days or units of service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0318	MANUAL PRICE-REQUIRES REPORT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	CO
0319	ENCOUNTER FMR ICN MISSING	243	Services not authorized by network/primary care providers.	N59	Please refer to your provider manual for additional program and provider information.	CO
0320	ENCOUNTER FMR ICN ALREADY ADJUSTED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N59	Please refer to your provider manual for additional program and provider information.	OA
0321	PROCEDURE CODE NOT ALLOWED FOR DATE OF SERVICE	181	Payment adjusted because this procedure code was invalid on the date of service	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0324	DIAGNOSIS INCOMPATIBLE WITH MEMBERS SEX	10	The diagnosis is inconsistent with the patient's gender.	N59	Please refer to your provider manual for additional program and provider information.	CO
0325	CLAIM/DETAIL DENIED. SCREENING PROCEDURE CODE INVALID FOR MEMBERS AGE	6	The procedure/revenue code is inconsistent with the patient's age.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
0326	CLAIM DENIED. BILL/INVOICE MUST ACCOMPANY CLAIM.	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M23	Missing invoice.	CO
0329	SECONDARY SURGICAL PROCEDURE REQUIRES PRIOR AUTHORIZATION	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
0330	DETAIL DENIED. DETAIL UNITS BILLED EXCEED UNITS PRIOR AUTHORIZED	198	Payment Adjusted for exceeding precertification/ authorization.	M62	Missing/incomplete/invalid treatment authorization code.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0331	PAYMENT REDUCED BY AMOUNT PREVIOUSLY PAID. POST OP INCLUDED IN PROCEDU	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	OA
0333	THE SUM OF THE MEDICARE DEDUCTIBLE AND COINSURANCE IS GREATER THAN THE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO
0334	SUPPLY NOT COVERED ON RENTAL ITEM	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N171	Payment for repair or replacement is not covered or has exceeded the purchase price.	CO
0336	INVALID PATIENT RESPONSIBILITY	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N58	Missing/incomplete/invalid patient liability amount.	CO
0337	ENCOUNTER CMO ID MISSING OR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA112	Missing/incomplete/invalid group practice information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0338	FINANCIAL CLASS - PATIENT RESPONSIBILITY	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N58	Missing/incomplete/invalid patient liability amount.	CO
0339	INSURANCE CODE 04 HAS BEEN SUBMITTED WITH THE CLAIM	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA92	Missing plan information for other insurance. (Modified 2/1/04) Related to N245	CO
0340	ONLY THREE FOLLOW UP EXAMS ALLOWED DURING THE SIX MONTH PERIOD FOLLOWI	119	Benefit maximum for this time period or occurrence has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0341	ENCOUNTER FMR ICN IS DENIED	242	Services not provided by network/primary care providers.	N59	Please refer to your provider manual for additional program and provider information.	CO
0342	OFFICE VISIT AND/OR ER VISIT ARE NOT PAYABLE ON THE SAME DOS AS A CONS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
0343	MEDICARE PAYMENT DATE IS BEFORE TO DOS OR AFTER BATCH DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N307	Missing/incomplete/invalid adjudication or payment date.	CO
0344	PART B CLAIM NEEDS MEDICARE PAYMENT, CO-INSURANCE OR DEDUCTIBLE	2	Coinsurance Amount	N8	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.	PR

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0345	MEDICARE PAID DATE IS LESS THAN 45 DAYS FROM ICN DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N307	Missing/incomplete/invalid adjudication or payment date.	CO
0346	INVALID NUMBER OF DAYS COVERED	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA32	Missing/incomplete/invalid number of covered days during the billing period.	CO
0348	ROOM CHARGES REDUCED TO SEMI PRIVATE RATE	78	Non-Covered days/Room charge adjustment.	N153	Missing/incomplete/invalid room and board rate.	CO
0351	PLEASE CHECK SUBMITTED CHARGE FOR QUANTITY BILLED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	M79	Missing/incomplete/invalid charge.	CO
0358	TREATING PROVIDER/REFERRING PROVIDER NUMBER ARE EQUAL	148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.	N55	Procedures for billing with group/referring/performing providers were not followed.	OA
0361	PROCEDURE NOT ON FILE	181	Payment adjusted because this procedure code was invalid on the date of service	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
0362	MEDICARE DEDUCTIBLE GREATER THAN ALLOWED DEDUCTIBLE	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N408	This payer does not cover deductibles assessed by a previous payer.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0363	ROOT REMOVAL NOT PAYABLE ON SAME DOS AS THE TOOTH EXTRACTION	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
0364	PAYMENT REDUCED BY OTHER INSURANCE	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N131	Total payments under multiple contracts cannot exceed the allowance for this service.	OA
0365	FEE ADJUSTED TO MAXIMUM ALLOWABLE	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N524	Based on policy this payment constitutes payment in full.	CO
0366	CLAIM DENIED. BILLED AMOUNT MAY NOT EXCEED $50.00 PER UNIT OF SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0367	THIS SERVICE PAID COINSURANCE AND/OR DEDUCTIBLE	1	Deductible Amount	MA125	Per legislation governing this program, payment constitutes payment in full.	PR
0368	PROVIDER IS NOT ELIGIBLE TO BILL FOR HOME HEATLH SUPPLIES OR VISITS	185	The rendering provider is not eligible to perform the service billed.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
0369	ORIGINAL PSYCHIATRIC EVALUATION AND REGULAR HOSPITAL ADMISSION NOT PAY	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
0370	PAYMENT MODE NOT FOUND FOR PAYEE PROVIDER	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
0371	REIMBURSEMENT RATE NOT FOUND FOR DATE OF SERVICE	147	Provider contracted/negotiated rate expired or not on file.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0372	HOSPITAL FOLLOW-UP VISITS AND ORIGINAL PSYCHIATRIC DIAGNOSTIC EVAL AND	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
0373	UNITS OF SERVICE HAVE BEEN REDUCED TO THE REMAINING PRIOR AUTHORIZED Q	198	Payment Adjusted for exceeding precertification/ authorization.	N45	Payment based on authorized amount.	CO
0374	REPAYMENT PORTION OF THIS ADJUSTMENT HAS BEEN DENIED. RECOUPMENT IS UN	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N59	Please refer to your provider manual for additional program and provider information.	CO
0377	MEMBER INCOME/PATIENT LIABILITY DEDUCTION DOES NOT APPLY TO THIS CLAIM	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N524	Based on policy this payment constitutes payment in full.	CO
0378	AGE RESTRICTION FOR COVERED ICD PROCEDURE	6	The procedure/revenue code is inconsistent with the patient's age.	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
0379	PAID BY MEDICAID	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	MA125	Per legislation governing this program, payment constitutes payment in full.	CO
0380	CO-PAY WAS DEDUCTED FROM REIMBURSEMENT	3	Co-payment Amount	N524	Based on policy this payment constitutes payment in full.	PR
0381	CERTAIN SPECIFIED PROCEDURES ARE NOT REIMBURSABLE FOR SAME DATE OF SE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0383	CERTAIN INCIDENTAL SURGERIES ARE NOT REIMBURSABLE FOR SAME DATE OF SER	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
0384	DETAIL DENIED. INVOICE MUST BE ATTACHED WHEN BILLING IMPLANTABLES.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M23	Missing invoice.	CO
0385	CERTAIN INCIDENTAL PROCEDURES ARE NOT REIMBURSABLE FOR THE SAME DATE O	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
0386	DETAIL DENIED. INVOICE AMOUNT MUST MATCH BILLED AMOUNT.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N29	Missing documentation/orders/notes/summary/report/chart. (Modified 2/28/03, 8/1/05) Related to N225	CO
0387	CERTAIN INCIDENTAL SURGERIES AND PELVIC SURGERIES ARE NOT REIMBURSABLE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
0388	THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE ANCILL	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M50	Missing/incomplete/invalid revenue code(s).	CO
0390	CLAIM DENIED. DUPLICATE SERVICE BILLED	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
0391	ENCOUNTER FROM DATE OF SERVICE IS INVALID - HEADER	242	Services not provided by network/primary care providers.	M52	Missing/incomplete/invalid 'from' date(s) of service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0392	DETAIL DENIED. PROCEDURE CODES X0061, X0088 AND X0089 NOT PAYABLE ON T	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
0393	CLAIM DENIED. THE PRIMARY DIAGNOSIS CODE IS NOT VALID FOR THIS PROVIDE	12	The diagnosis is inconsistent with the provider type.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
0394	HOURLY RESPITE SERV NOT ALLOWED FOR SAME DATE OF SERVICE AS DAILY RESP	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
0395	AMOUNT PD BY OTHER INSURANCE EQUALS OR EXCEEDS AMOUNT OF MEDICAID REIM	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N131	Total payments under multiple contracts cannot exceed the allowance for this service.	OA
0396	DAILY RESPITE SERVICES NOT ALLOWED FOR SAME DOS AS HOURLY RESPITE S	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
0397	ACCOMMODATION REVENUE CODES MUST BE BILLED ON AN INPATIENT CLAIM	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M50	Missing/incomplete/invalid revenue code(s).	CO
0398	THE PROCEDURE CODE MODIFIER IS MISSING OR INVALID.	182	Payment adjusted because the procedure modifier was invalid on the date of service	N519	Invalid combination of HCPCS modifiers.	CO
0399	CLAIM/DETAIL DENIED. THIS SERVICE NOT COVERED FOR THIS MEMBER.	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0401	ELECTRONIC ADJUSTMENT/VOID CLAIMS DO NOT MATCH	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA47	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment.	CO
0402	POSSIBLE SUBSTANCE ABUSE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
0403	RETURN THE INVOICE TO THIS OFFICE WITH THE DATE(S) OF SURGERY	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M23	Missing invoice.	CO
0406	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. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M53	Missing/incomplete/invalid days or units of service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0407	PLACE 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. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M77	Missing/incomplete/invalid place of service.	CO
0408	INVALID OR SPANNED HEADER DATES	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N64	The 'from' and 'to' dates must be different.	CO
0409	INVALID PROVIDER TYPE BILLED ON CLAIM FORM	170	Payment is denied when performed/billed by this type of provider.	N95	This provider type/provider specialty may not bill this service.	CO
0410	FORMAT INVALID FOR ELECTRONIC CLAIMS.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	CO
0411	DUE TO THE END OF YOUR FISCAL YEAR, PLEASE REBILL THESE MULTIPLE MONTH	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.	CO
0412	DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL.	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N64	The 'from' and 'to' dates must be different.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0413	MEMBER NOT ENROLLED IN MANAGED CARE DURING DATES OF SERVICE	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO
0414	MEMBER ENROLLED IN MANAGED CARE DURING DATES OF SERVICE	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	N30	Patient ineligible for this service.	OA
0415	FFS CLAIM HAS A MANAGED CARE PROVIDER TYPE	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	N95	This provider type/provider specialty may not bill this service.	OA
0416	NO BASE RATE ON FILE FOR DATES OF SERVICE	147	Provider contracted/negotiated rate expired or not on file.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
0419	INDEPENDENT LABORATORY - INVALID PLACE OF SERVICE	58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.	CO
0420	CLAIM DENIED. INVALID ENC PAYMENT AMOUNT.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N232	Incomplete/invalid itemized bill.	CO
0421	CLAIM DENIED. INVALID ENC PAYMENT DATE.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N307	Missing/incomplete/invalid adjudication or payment date.	CO
0422	CLAIM DENIED. INVALID ENC ADJUSTMENT TCN.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M47	Missing/incomplete/invalid internal or document control number.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0423	CLAIM DENIED. INVALID MEMBER NOT ELIG FOR PHYSICAL.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N30	Patient ineligible for this service.	CO
0424	CLAIM DENIED. INVALID MEMBER NOT ELIG FOR BEHAVIORAL.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N30	Patient ineligible for this service.	CO
0425	DATE SPAN BILLING NOT ALLOWED FOR THIS PROC CODE. BILL EACH DATE OF SE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N61	Rebill services on separate claims.	CO
0426	THE 36 MONTH MAXIMUM FOR THIS SERVICE HAS BEEN EXCEEDED. THE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0427	CLAIM DENIED. RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM WITH JUSTIF	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
0429	THE DATES OF SERVICE CAN NOT SPAN ACROSS CALENDAR YEARS	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO
0430	MULTIPLE SURGERY WITHIN 2 DAYS IS SUSPENDED FOR REVIEW	59	Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	N35	Program integrity/utilization review decision.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0431	DME SUPPLIES MUST BE BILLED MONTHLY - NOT TO EXCEED 31 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
0432	DATES EXCEED 14 DAYS ON ONE LINE FOR THIS PROCEDURE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0438	CLAIM DETAIL DENIED. PROCEDURE CODE 90853 IS LIMITED TO 6 UNITS PER DA	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0439	THE MEMBER ID IS MISSING OR INVALID	140	Patient/Insured health identification number and name do not match.	N382	Missing/incomplete/invalid patient identifier.	CO
0441	CLAIM/DETAIL DENIED. PROCEDURE CODES 99244 AND 99245 ARE LIMITED CUMUL	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
0442	CLAIM/DETAIL DENIED. THIS PROCEDURE CODES IS NOT PAYABLE ON THE SAME D	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N20	Service not payable with other service rendered on the same date.	CO
0443	CLAIM/DETAIL DENIED. PROCEDURE CODES 99244 AND 99245 ARE NOT PAYABLE O	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N20	Service not payable with other service rendered on the same date.	CO
0444	PLEASE CORRECT INVALID OR MISSING NDC NUMBER	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
0445	CLAIM/DETAIL DENIED. PROCEDURE CODE 99244 IS LIMITED TO ONE PER FIVE Y	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0446	CLAIM/DETAIL DENIED. PROCEDURE CODE 99245 IS LIMITED TO ONE PER FIVE Y	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0447	THE CONDITION CODE IS INVALID FOR DIALYSIS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
0450	INVALID QUADRANT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N346	Missing/incomplete/invalid oral cavity designation code.	CO
0454	CLAIM/DETAIL DENIED. X0079/H0039 LIMITED TO 32 UNITS PER DAY.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
0455	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
0456	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
0457	CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT,	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0458	CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO $150.00 PER DAY.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0459	CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0460	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0461	CLAIM/DETAIL DENIED. XL307/97535 LIMITED TO 80 UNITS PER WEEK.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0462	PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N95	This provider type/provider specialty may not bill this service.	CO
0463	OCCURRENCE SPAN FROM DATE IS GREATER THAN THE OCCURRENCE SPAN TO DATE	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N300	Missing/incomplete/invalid occurrence span date(s).	CO
0465	MEMBER COVERED BY PRIVATE INSURANCE (NO ATTACHMENT)	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO
0466	DETAIL DENIED. EARLY INTERVENTION AND CERTAIN EPSDT-SPECIAL SERVICES P	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
0467	MEMBER HAS OTHER MEDICAL COVERAGE. BILL OTHER INSURANCE FIRST OR ATTAC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO
0468	ADJUSTMENT EXCEEDS 7 YEAR LIMIT AND CANNOT BE REPLACED	29	The time limit for filing has expired.	N185	Do not resubmit this claim/service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0470	THE UNITS OF SERVICE BILLED WAS NOT WITHIN THE SPECIFIED RANGE ALLOWED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0471	QMB MEMBER ELIGIBLE FOR MCARE CROSSOVERS ONLY	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N192	Patient is a Medicaid/Qualified Medicare Beneficiary.	CO
0473	MEDICAID REIMBURSEMENT FOR THIS DOS HAS ALREADY BEEN MADE. CLAIM PAYME	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
0474	SURGICAL PROCEDURE OR DATE OF SURGERY IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N341	Missing/incomplete/invalid surgery date.	CO
0475	ENCOUNTER PAY-TO NOT WITHIN SUBMITTER PROVIDER NETWORK	38	Services not provided or authorized by designated (network/primary care) providers.	N198	Rendering provider must be affiliated with the pay-to provider.	CO
0476	MEMBER IN AN INSTITUTIONAL SETTING DURING THE SAME DATE OF SERVICE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
0477	MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DOS	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
0478	YOUR FACILITY HAS PREVIOUSLY BILLED AND RECEIVED PAYMENT FOR ALL OR A	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
0479	NO CLIA REGISTRATION ON FILE FOR THIS PROVIDER	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA120	Missing/incomplete/invalid CLIA certification number.	CO
0480	PAY TO PROVIDER NOT AUTHORIZED FOR DIRECT PAYMENT. CONTACT PROVIDER EN	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N24	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0481	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
0482	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
0483	DUPLICATE ANESTHESIA SERVICE BILLED BY PHYSICIAN AND NURSE ANESTHETIST	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
0484	ONLY ONE ANESTHESIA ALLOWED PER DOS PER MEMBER	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0485	PAPER ATTACHMENT NOT RECEIVED WITHIN 21 DAYS	164	Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion.	N223	Missing documentation of benefit to the patient during initial treatment period.	CO
0486	DETAIL PLACE OF SERVICE NOT COVERED THROUGH THE PODIATRY PROGRAM	58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	M77	Missing/incomplete/invalid place of service.	CO
0487	ROUTINE FOOT CARE IS NOT PAYABLE FOR THIS DIAGNOSIS	11	The diagnosis is inconsistent with the procedure.	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
0488	ABORTION CERTIFICATION MISSING	197	Payment adjusted for absence of precertification/ authorization.	N29	Missing documentation/orders/notes/summary/report/chart. (Modified 2/28/03, 8/1/05) Related to N225	CO
0489	CLAIM DENIED. THIS SERVICE WAS PREVIOUSLY PAID TO ANOTHER PROVIDER.	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
0490	CONSECUTIVE OUTPATIENT SERVICES ARE NON-PAYABLE DURING A HOSPITAL INPA	60	Charges for outpatient services with this proximity to inpatient services are not covered.	N47	Claim conflicts with another inpatient stay.	CO
0491	CLAIM DENIED. MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	CO
0494	DETAIL DENIED. THIS SERVICE IS NOT PAYABLE BEYOND THE BIRTH MONTH OF T	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0495	INVALID HOSPICE REVENUE CODE OR COMBINATION OF HOSPICE REVENUE CODES	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M50	Missing/incomplete/invalid revenue code(s).	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0496	ONLY ONE (1) ANESTHESIA\IV SEDATION ALLOWED PER DATE OF SERVICE PER ME	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0497	CLAIM/DENIED. RESUBMIT AN ADJUSTMENT ON ADJUSTMENT REQUEST FORM.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N142	The original claim was denied. Resubmit a new claim, not a replacement claim.	CO
0498	ONLY ONE PAYMENT ALLOWED PER MEMBER, PER DATE OF SERVICE.	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
0499	CLAIM PENDING REVIEW OF HISTORY	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
0500	BIFOCAL OR SINGLE VISION LENSES LIMITED TO TWO SETS PER 12 MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0501	PROFESSIONAL FEE-DISPENSING SERVICE ALLOWED ONCE PER 12 MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0504	ENCOUNTER FDOS IS AFTER THROUGH DOS - DETAIL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M52	Missing/incomplete/invalid 'from' date(s) of service.	CO
0506	BILLED DATE GREATER THAN BATCH DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO
0509	MEMBERS ARE LIMITED ON INITIAL AND FOLLOW UP VISITS TO ONE PER YEAR, P	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0510	MEMBER LIMITED ON SELECTED INITIAL AND FOLLOW UP VISITS TO 1 PER DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
0511	PAYMENT FOR REVISION OF ARTERIOVENOUS SHUNT IS INCLUDED IN FEE FOR INI	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
0512	CLAIM DENIED. FOLLOW UP VISIT INCLUDED IN REIMBURSEMENT FOR DELIVERY.	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N525	These services are not covered when performed within the global period of another services.	OA
0513	FOLLOW-UP HOSPITAL VISITS INCLUDED IN REIMBURSEMENT FOR C-SECTION	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N525	These services are not covered when performed within the global period of another services.	OA
0514	CAST APPLICATION/REMOVAL INCLUDED IN REIMBURSEMENT FOR SURGERY	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N525	These services are not covered when performed within the global period of another services.	OA
0517	ADMISSION DATE CANNOT BE GREATER THAN THE FDOS	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA40	Missing/incomplete/invalid admission date.	CO
0518	CLAIM/DETAIL DENIED. INITIAL TOOTH EXTRACTION LIMITED TO ONE PER DOS/M	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0519	CLAIM DENIED. REIMBURSEMENT FOR CIRCUMCISION WITHIN TEN DAYS OF DELIVE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N525	These services are not covered when performed within the global period of another services.	OA
0524	ENCOUNTER TDOS INVALID OR FUTURE DATE - HEADER	110	Billing date predates service date.	M59	Missing/incomplete/invalid 'to' date(s) of service.	CO
0525	ENCOUNTER TDOS INVALID OR FUTURE DATE - DETAIL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M59	Missing/incomplete/invalid 'to' date(s) of service.	CO
0535	POSITIVE ADJUSTMENT EXCEEDS FILING DEADLINE	29	The time limit for filing has expired.	N59	Please refer to your provider manual for additional program and provider information.	CO
0538	THIS PROCEDURE REQUIRES PRIOR AUTHORIZATION	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
0542	SERVICE DENIED AS A PASRR SERVICES DUPLICATE	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
0543	SERVICE ALLOWED AS A PASRR SERVICES DUPLICATE	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	M79	Missing/incomplete/invalid charge.	CO
0548	INVALID PATIENT STATUS FOR DIALYSIS MEMBER�?	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA43	Missing/incomplete/invalid patient status.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0550	PROCEDURE CODE 00140/D0140 CAN ONLY BE BILLED ALONE OR WITH MONITORED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	CO
0552	THE STAY DAYS BILLED EXCEEDS THE MAXIMUM NUMBER OF STAY DAYS FOR THIS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0554	THE DATE OF SERVICE AND/OR DOLLAR AMOUNTS ON THE CLAIM AND MEDICARE EO	129	Payment denied - Prior processing information appears incorrect.	N4	Missing/incomplete/invalid prior insurance carrier EOB.	PI
0555	DTL - CROSSOVER CLAIM EXCEEDS FILING LIMIT. LIMIT IS 12 MOS FROM MEDIC	29	The time limit for filing has expired.	N102	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	CO
0556	CLAIM/DETAIL DENIED. MEMBER MUST BE AN INPATIENT IN THE NURSING FACILI	60	Charges for outpatient services with this proximity to inpatient services are not covered.	N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.	CO
0557	DTL - CROSSOVER CLAIM EXCEEDS FILING LIMIT. LIMIT IS 12 MONTHS FROM ME	29	The time limit for filing has expired.	N59	Please refer to your provider manual for additional program and provider information.	CO
0560	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.	198	Payment Adjusted for exceeding precertification/ authorization.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0561	INVALID NURSING HOME LEVEL OF CARE	150	Payment adjusted because the payer deems the information submitted does not support this level of service.	N59	Please refer to your provider manual for additional program and provider information.	CO
0562	INVALID NURSING HOME LEVEL OF CARE	150	Payment adjusted because the payer deems the information submitted does not support this level of service.	N59	Please refer to your provider manual for additional program and provider information.	CO
0565	THE SUM OF THE THIRD PARTY PAYMENT AMOUNTS ENTERED ON THE LINE ITEM(S)	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N48	Claim information does not agree with information received from other insurance carrier.	CO
0568	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.	198	Payment Adjusted for exceeding precertification/ authorization.	M139	Denied services exceed the coverage limit for the demonstration.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0569	THE ACCIDENT DATE IS AFTER THE THROUGH DATE OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N400	Alert: Electronically enabled providers should submit claims electronically.	CO
0572	DETAIL DENIED. LEAD INVESTIGATION IN THE HOME LIMITED TO TWO (2) SERVI	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0578	DOS IS BEFORE MEMBERS BIRTH DATE ON FILE. CORRECT OR SUBMIT PROOF OF	14	The date of birth follows the date of service.	N329	Missing/incomplete/invalid patient birth date.	CO
0579	PSYCHIATRIC SERVICES ARE LIMITED TO SHORT TERM ACUTE CARE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0580	THE COMPUTED OR SUBMITTED CLAIM FORM FROM AND TO DATES OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO
0588	MOTHER DISCHARGE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N318	Missing/incomplete/invalid discharge or end of care date.	CO
0589	ADJUSTMENT IS SUSPENDED FOR PRE - PAYMENT VERIFICATION	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N35	Program integrity/utilization review decision.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0590	HOSP DAYS OVERLAP FISCAL YEAR END - BEGIN DATES	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO
0591	5TH SURGERY DATE/STAY CONFLICT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N20	Service not payable with other service rendered on the same date.	CO
0592	6TH SURGERY DATE/STAY CONFLICT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N20	Service not payable with other service rendered on the same date.	CO
0593	4TH SURGICAL PROCEDURE DATE INVALID	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N341	Missing/incomplete/invalid surgery date.	CO
0594	5TH SURGICAL PROCEDURE DATE INVALID	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N431	Service is not covered with this procedure.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0595	CLAIM SUSPENDED FOR DCH REVIEW	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N35	Program integrity/utilization review decision.	CO
0596	CLAIM DETAIL DENIED. OFFICE VISITS NOT ALLOWED WITHIN 10 DAYS FOLLOWIN	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	OA
0597	CLAIM/DETAIL DENIED. THIS PROCEDURE IS NOT PAYABLE AFTER THE DATE OF D	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	OA
0598	ONLY ONE E AND M CODE ALLOWED PER DATE OF SERVICE.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0599	CLAIM PENDING REVIEW OF HISTORY	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
0600	EYE EXAM LIMITED TO OPTOMETRIST	170	Payment is denied when performed/billed by this type of provider.	N95	This provider type/provider specialty may not bill this service.	CO
0601	ONLY 3 FOLLOW UP EXAMS ARE ALLOWED PER 6 MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0602	CLAIM DENIED. LIMIT 2 ROUTINE ORTHODONTICS PER MEMBER, PER 12 MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0603	CLAIM DENIED. EACH MEMBER ALLOWED ONE FULL MOUTH RADIOGRAPHY EVERY TW	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0604	INVALID FINANCIAL CLASS CODE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N239	Incomplete/invalid physician financial relationship form.	CO
0605	6TH THRU 11TH DIAG CODE IS NOT FOUND	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0606	6TH DIAG CODE REQUIRES MED REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
0607	7TH DIAG CODE REQUIRES MED REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
0608	8TH DIAG CODE REQUIRES MED REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
0609	9TH DIAG CODE REQUIRES MED REVIEW	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N35	Program integrity/utilization review decision.	CO
0610	10TH DIAG CODE REQUIRES MED REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
0611	11TH DIAG CODE REQUIRES MED REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
0612	12TH - 25TH DIAG CODE REQUIRES MED REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
0618	4TH SURGICAL PROCEDURES/SEX CONFLICT	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
0619	5TH SURGICAL PROCEDURES/SEX CONFLICT	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
0620	6TH SURGICAL PROCEDURES/SEX CONFLICT	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
0623	6TH SURGICAL PROCEDURE NOT FOUND	181	Payment adjusted because this procedure code was invalid on the date of service	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
0624	THIS PROCEDURE ALLOWED ONE PER DOS PER TOOTH PER PROVIDER	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0625	CLAIM DENIED/MEMBER ALLOWED 3 REPAIRS INCLUDING REPLACEMENTS OF ONE TO	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0630	SERVICE DATES SPAN MORE THAN ONE DAY OF SERVICE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO
0632	FULL MOUTH DEBRIDEMENT IS ALLOWED ONCE PER MEMBER PER PREGNANCY	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0633	DIAGNOSIS REQUIRES PRIOR AUTHORIZATION	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
0636	PROFESSIONAL FEE FOR DISPENSING INITIAL PAIR OF EYEGLASSES ALLOW - ONE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0637	CLAIM DENIED. MEMBER LIMITED TO 3 FETAL TESTS/12 MONTHS. IF UNUSUAL CI	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0639	ADJUSTMENT WAS AUTODENIED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA67	Correction to a prior claim.	CO
0641	MEMBER NOT AUTHORIZED BY PROVIDER FOR INSTITUTIONAL STAY	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N30	Patient ineligible for this service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0643	NEW RESUBMISSION ADJUSTMENTS	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA67	Correction to a prior claim.	CO
0644	MEMBERS ARE LIMITED TO ONE (1) OPTHAMOLOGICAL EXAMINATION PER PROVIDER	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0645	NEW PATIENT HOME MEDICAL SERV LIMITED TO ONE PER MEMBER PER PROVIDER P	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0651	WAITING FOR ATTACHMENT FROM PROVIDER	163	Claim/Service adjusted because the attachment referenced on the claim was not received.	N223	Missing documentation of benefit to the patient during initial treatment period.	CO
0652	CLAIM DENIED. BIFOCAL OR SINGLE VISION LENSES ARE LIMITED TO 4 PER 12	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0653	ENCOUNTER FIRST DIAGNOSIS IS INVALID	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
0654	ENCOUNTER ADMIT DIAGNOSIS IS INVALID	167	This (these) diagnosis(es) is (are) not covered.	MA65	Missing/incomplete/invalid admitting diagnosis.	CO
0657	DUPLICATE DIAGNOSIS CODE SEQUENCE VALUE DETECTED	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
0658	GAP IN DIAGNOSIS CODE SEQUENCE VALUE DETECTED	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
0660	CALCULATED PAYMENT EQUALS ZERO	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N524	Based on policy this payment constitutes payment in full.	CO
0661	SNU LEAVE DAYS PRESENT	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N43	Bed hold or leave days exceeded.	CO
0664	PAY TO PROVIDERS MAIL IS UNDELIVERABLE. CONTACT PROVIDER ENROLLMENT FO	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N281	Missing/incomplete/invalid pay-to provider address.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0667	THIS PROCEDURE IS LIMITED TO ONE SERVICE PER MEMBER PER SAME DATE OF S	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0668	PROVIDER/PROC CODE MOD/PLACE OF SERV CONFLICT. POST WITH ASC MOD 73 O	58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	MA109	Claim processed in accordance with ambulatory surgical guidelines.	CO
0669	DAYS REDUCED. A MAXIMUM OF 14 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0670	DAYS REDUCED. A MAXIMUM OF 15 NON-HOSPITAL RESERVE DAYS ALLOWED PER ME	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0671	CLAIM/DETAIL DENIED. MEDICAID WILL PAY FOR ONLY ONE CARDIAC CATHETER P	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0673	CLAIM DENIED. CPT LEVEL CODE MISSING OR INVALID.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
0674	PROCEDURE CODE V5020 IS LIMITED TO 3 PER MEMBER PER PROVIDER PER SIX M	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0681	RENDERING PROVIDER NOT ELIGIBLE AT SERVICE LOCATION FOR PROGRAM BILLED	171	Payment is denied when performed/billed by this type of provider in this type of facility.	MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.	CO
0699	CLAIM/DETAIL DENIED. PROCEDURE CODE T2022 IS LIMITED TO $260.00 IN	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M139	Denied services exceed the coverage limit for the demonstration.	CO
0712	PROCEDURE CODE/PROVIDER TYPE OF SERVICE CONFLICT (WAIVER PROGRAM AND C	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	N95	This provider type/provider specialty may not bill this service.	CO
0713	DELIVERY, ROUTINE NEWBORN CARE, CIRCUMCISION ARE LIMITED TO ONE EACH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0720	MEDICARE COVERAGE IS PRESENT	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0721	MEMBER INELIG FOR DOS - DENIED AFTER PENDING FOR 14 DAYS AWAITING DCH	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
0735	CLAIM/DETAIL DENIED. SYRINGES LIMITED TO 125 UNITS PER 26 DAYS, PER ME	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0736	CLAIM/DETAIL DENIED. VACCINE ADMINISTRATION LIMITED TO (3) PER MEMBER,	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0737	INVALID PROCEDURE CODE AND MODIFIER	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	N519	Invalid combination of HCPCS modifiers.	CO
0755	NON-REIMBURSABLE FOR THIS PROVIDER TYPE/DOS. EFFECTIVE FOR DOS 10/01/9	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	N95	This provider type/provider specialty may not bill this service.	CO
0756	CLIA ID MISSING OR INVALID. CHARGES MOVED TO NON-COVERED.	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA120	Missing/incomplete/invalid CLIA certification number.	CO
0766	PROV CTRC - PROCEDURE NOT BILLABLE WITH REVENUE	199	Revenue code and Procedure code do not match.	M67	Missing/incomplete/invalid other procedure code(s). (Modified 12/2/04) Related to N302	CO
0778	VARIANCE LIMIT MET. CLAIM PENDING REVIEW.	133	The disposition of this claim/service is pending further review.	N59	Please refer to your provider manual for additional program and provider information.	PI
0779	INVALID PROCEDURE CODE MODIFIER	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	N59	Please refer to your provider manual for additional program and provider information.	CO
0781	CLAIM/DETAIL DENIED. THE MEMBERS ANNUAL SPEECH THERAPY VISIT LIMIT.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0782	CLAIM/DETAIL DENIED. THE MEMBERS ANNUAL PHYSICAL THERAPY VISIT LIMIT.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0783	FULL MOUTH DEBRIDEMENT NOT ALLOWED ON SAME DATE OF SERVICE AS PROPHY	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N20	Service not payable with other service rendered on the same date.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0784	PROPHY/PERIODONTAL SCALING AND ROOT PLANNING NOT ALLOWED ON SAME DOS	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N20	Service not payable with other service rendered on the same date.	CO
0785	CLAIM/DETAIL DENIED. ONLY ONE DENTAL VISIT ALLOWED PER MEMBER PER	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0786	CAST PROCEDURES ARE LIMITED TO TWO PER 90 DAYS PER BODY PART	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0792	CLAIM DETAIL DENIED. ONLY ONE OBSTETRICAL VISIT ALLOWED IN AN EIGHT WE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0793	CLAIM DETAIL DENIED. ONLY ONE COMPREHENSIVE VISIT ALLOWED EVERY 50 WEE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0794	CLAIM/DETAIL DENIED. EPIDURAL INJECTIONS FOR CONTROL OF PAIN SHALL BE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0796	CLAIM/DETAIL REQUIRES PRIOR AUTHORIZATION. THE ANNUAL (CALENDAR YEAR)	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0797	THE ANNUAL MAXIMUM FOR THIS SERVICE HAS BEEN EXCEEDED. THE ALLOWED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0798	PROCEDURE CODE XZ299 IS LIMITED TO $150.00 PER CALENDAR MONTH PER MEMB	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0800	CLAIM DENIED. PROCEDURE CODES X0074 AND X0075 NOT PAYABLE ON SAME DATE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
0802	PROCEDURE CODE 00150/D0150 DISALLOWED BY SAME PROVIDER FOR SAME MEMBER	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0813	OCCURRENCE/VALUE CODE REQUIRED FOR THERAPY AND PSYCHIATRIC SERVICES	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M45	Missing/incomplete/invalid occurrence code(s). (Modified 12/2/04) Related to N299	CO
0814	MEMBER NUMBER INVALID	31	Claim denied as patient cannot be identified as our insured.	N30	Patient ineligible for this service.	CO
0822	OCCURRENCE/VALUE CODES REQUIRED FOR THERAPY AND PSYCHIATRIC SERVICES�?	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M45	Missing/incomplete/invalid occurrence code(s). (Modified 12/2/04) Related to N299	CO
0824	ADJ PAY-TO PROV NOT EQUAL TO THE CLAIM PAY-TO PROV	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	N280	Missing/incomplete/invalid pay-to provider primary identifier.	CO
0825	OPERATING ROOM AND KIDNEY TRANSPLANT MUST BE BILLED TOGETHER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N214	Missing/incomplete/invalid history of the related initial surgical procedure(s)	CO
0826	OTHER CARRIER OR INSURANCE COMPANY DENIAL NOT RECEIVED WITHIN 30 DAYS	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0827	OPERATING ROOM AND KIDNEY TRANSPLANT MUST BE BILLED TOGETHER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N214	Missing/incomplete/invalid history of the related initial surgical procedure(s)	CO
0830	CLAIM DENIED. DRG NOT ON FILE.	A8	Claim denied; ungroupable DRG	N208	Missing/incomplete/invalid DRG code	CO
0831	CLAIM DENIED. DRG CANNOT USE DIAGNOSIS CODE.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA63	Missing/incomplete/invalid principal diagnosis.	CO
0832	CLAIM DENIED. DRG CRITERIA NOT MET.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N208	Missing/incomplete/invalid DRG code	CO
0833	CLAIM DENIED. DRG INVALID AGE.	A8	Claim denied; ungroupable DRG	N208	Missing/incomplete/invalid DRG code	CO
0836	CLAIM DENIED. DRG INVALID PRINCIPAL DIAGNOSIS.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA63	Missing/incomplete/invalid principal diagnosis.	CO
0837	CLAIM DENIED. DRG DENY 469 THROUGH 470.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N208	Missing/incomplete/invalid DRG code	CO
0842	PROCEDURE CODE IS MUTUALLY EXCLUSIVE	231	Mutually exclusive procedures cannot be done in the same day/setting.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0843	PROCEDURE CODE IS INCIDENTAL	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N19	Procedure code incidental to primary procedure.	OA
0849	PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	N95	This provider type/provider specialty may not bill this service.	CO
0854	MATERNITY PROCEDURE AGE SHOULD BE 12 - 55 YEARS	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0856	PROCEDURE NOT INDICATED FOR A MALE	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
0859	CLAIM DENIED. DUPLICATE PROCEDURE.	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
0860	CLAIM DENIED. EXPERMENTAL PROCEDURE.	55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
0867	PROCEDURE CODE NEEDS TO BE REPLACED FOR SURFACES BILLED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N81	Procedure billed is not compatible with tooth surface code.	CO
0868	CLAIM/DETAIL DENIED. PURCHASE OF PROCEDURE CODES E0607 AND E2100 IS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N59	Please refer to your provider manual for additional program and provider information.	OA
0872	FIRST DIAGNOSIS CODE NOT ON FILE	147	Provider contracted/negotiated rate expired or not on file.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
0873	SECOND DIAGNOSIS CODE NOT ON FILE	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
0874	SECOND DIAGNOSIS CODE INVALID	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
0875	THIRD DIAGNOSIS CODE NOT ON FILE	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0876	CLAIM/DETAIL DENIED. HEARING AIDS ARE LIMITED TO $1400.00 PER EAR, PER	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0877	CLAIM/DETAIL DENIED. CHILDRENS DENTAL PROPHYLAXIS AND FLOURIDE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0878	FOURTH DIAGNOSIS CODE NOT ON FILE	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
0879	CLAIM DENIED. PROCEDURE REQUIRES DOCUMENTATION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N29	Missing documentation/orders/notes/summary/report/chart. (Modified 2/28/03, 8/1/05) Related to N225	CO
0881	CLAIM DENIED. PROCEDURE CODE IS FOR PATIENTS OVER AGE 14.	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0884	CLAIM DENIED PROCEDURE IS CONSIDERED EXPERIMENTAL	55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
0885	FIFTH DIAGNOSIS CODE NOT ON FILE	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
0886	FIFTH DIAGNOSIS CODE NOT ON FILE	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
0887	6TH THRU 11TH DIAG CODE IS NOT FOUND	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
0888	6TH THRU 11TH DIAG CODE IS NOT FOUND	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
0891	6TH THRU 11TH DIAG CODE IS NOT FOUND	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
0892	6TH THRU 11TH DIAG CODE IS NOT FOUND	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
0894	PA DOLLARS PARTIALLY AVAILABLE	198	Payment Adjusted for exceeding precertification/ authorization.	M139	Denied services exceed the coverage limit for the demonstration.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0897	EIGHTH DIAGNOSIS CODE INVALID	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
0898	6TH THRU 11TH DIAG CODE IS NOT FOUND	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
0899	NINTH DIAGNOSIS CODE INVALID	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
0901	QUANTITY DISPENSED IS MISSING OR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N374	Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required.	CO
0906	ACKNOWLEDGEMENT FORM INVALID/INCOMPLETE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	CO
0907	NDC IS NOT COVERED UNDER CONTRACT	204	This service/equipment/drug is not covered under the patient&#65533;s current benefit plan	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement	CO
0909	ANCILLARY INCLUDED IN PER DIEM PAYMENT	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M52	Missing/incomplete/invalid 'from' date(s) of service.	OA
0911	SYSTEM ERROR - CONTACT SE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M54	Missing/incomplete/invalid total charges.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0914	PAPER CLAIM REQUIRED. SUBMIT WITH REPORT/ATTACHMENT IF INDICATED.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N34	Incorrect claim form/format for this service.	CO
0915	NON-COVERED AMOUNT IS GREATER THAN BILLED AMOUNT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M54	Missing/incomplete/invalid total charges.	CO
0916	PROVIDER CONTRACT GROUP NOT FOUND	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N521	Mismatch between the submitted provider information and the provider information stored in our system.	CO
0921	CLAIM DENIED. THIRD PARTY LIABILITY AMOUNT IS EQUAL TO MEDICARE PAID A	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N48	Claim information does not agree with information received from other insurance carrier.	CO
0932	CLAIM/DETAIL DENIED. ONE DIALYSIS SERVICE ALLOWED PER MEMBER, PER PR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0936	CLAIM DENIED. MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME	B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
0937	CLAIM DENIED. PRESCRIPTION NUMBER REFILL DATE IS GREATER THAN ONE YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0938	CLAIM/DETAIL DENIED. MAXIMUM OF TEN NON-HOSPITAL RESERVE DAYS ALLOWED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0939	CLAIM/DETAIL DENIED. MAXIMUM OF 14 HOSPITAL RESERVE DAYS ALLOWED PER	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0941	CLAIM DENIED. CURRENT PROVIDER LICENSE NOT ON FILE.	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	N59	Please refer to your provider manual for additional program and provider information.	CO
0943	CLAIM/DETAIL DENIED. FRAMES OR COMPONENTS OF FRAMES ARE LIMITED TO 2	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0952	REIMBURSEMENT FOR THIS SERVICE IS INCLUDED IN THE TOTAL PAYMENT AMOUNT	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
0953	CONSENT FORM INCOMPLETE. YOU MAY COMPLETE ANY ITEM ON FORM EXCEPT, SIG	197	Payment adjusted for absence of precertification/ authorization.	N399	Incomplete/invalid elective consent form.	CO
0954	THE PROCEDURE CODE MODIFIER IS MISSING OR INVALID.	182	Payment adjusted because the procedure modifier was invalid on the date of service	N519	Invalid combination of HCPCS modifiers.	CO
0967	CLAIM DENIED. REIMBURSEMENT FOR THIS REVENUE CODE IS LIMITED TO TWO UN	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
0970	THIS PROCEDURE REQUIRES THE ENTRY OF A VALID ARCH CODE IN THE TOOTH NU	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N37	Missing/incomplete/invalid tooth number/letter.	CO
0974	DUPLICATE TOOTH NUMBERS ARE NOT ALLOWED ON THE SAME DETAIL FOR GINGIVE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
0975	UNITS NOT EQUAL TO TEETH BILLED	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M53	Missing/incomplete/invalid days or units of service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
0984	MEDICARE CO-INSURANCE MORE THAN 20 PERCENT MEDICARE ALLOWED AMOUNTED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO
0988	TOTAL MEDICARE ALLOWED AMOUNT IS NOT VALID	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M54	Missing/incomplete/invalid total charges.	CO
1001	COORDINATION OF BENEFITS CUTBACK	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
1002	RENDERING PROVIDER LICENSE EXPIRED	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M143	The provider must update license information with the payer.	CO
1003	APD GATEKEEPER ADJUSTMENT	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA67	Correction to a prior claim.	CO
1005	UNABLE TO DETERMINE PROVIDER SPECIALTY FOR THE DOS BILLED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N95	This provider type/provider specialty may not bill this service.	CO
1006	FACILITY PROVIDER NOT ELIGIBLE AT SERVICE LOCATION FOR PROGRAM BILLED	171	Payment is denied when performed/billed by this type of provider in this type of facility.	MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1009	UNABLE TO DETERMINE CATEGORY OF SERVICE. REFER TO YOUR BILLING MANUAL.	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N180	This item or service does not meet the criteria for the category under which it was billed.	CO
1010	ICD-10 DIAGNOSIS NOT SPECIFIC UB	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1016	NON-PARTICIPATING MANUFACTURER	111	Not covered unless the provider accepts assignment.	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO
1017	OVERNIGHT RESPITE SERVICES NOT ALLOWED WITH RESPITE SERVICES SAME DAY	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
1018	NO PRICING SEGMENT FOR LEVEL OF CARE	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N153	Missing/incomplete/invalid room and board rate.	CO
1019	MULTIPLE LEVELS OF CARE PER DIEM	59	Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	N153	Missing/incomplete/invalid room and board rate.	CO
1020	ICD-10 DIAGNOSIS NOT SPECIFIC PROF/DENTAL	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1021	FIRST OTHER PHYSICIAN ID NUMBER NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N270	Missing/incomplete/invalid other provider primary identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1023	NO INPATIENT CAP BASE RATE SEGMENT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
1026	PROCEDURE DATE AFTER BILLED DATE	110	Billing date predates service date.	N301	Missing/incomplete/invalid procedure date(s).	CO
1027	ICD FIRST SURGICAL PROCEDURE IS NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M67	Missing/incomplete/invalid other procedure code(s). (Modified 12/2/04) Related to N302	CO
1028	ICD SECOND SURGICAL PROCEDURE IS NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M67	Missing/incomplete/invalid other procedure code(s). (Modified 12/2/04) Related to N302	CO
1029	ICD THIRD SURGICAL PROCEDURE IS NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M67	Missing/incomplete/invalid other procedure code(s). (Modified 12/2/04) Related to N302	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1030	ICD FOURTH SURGICAL PROCEDURE IS NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M67	Missing/incomplete/invalid other procedure code(s). (Modified 12/2/04) Related to N302	CO
1031	ICD FIFTH SURGICAL PROCEDURE IS NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M67	Missing/incomplete/invalid other procedure code(s). (Modified 12/2/04) Related to N302	CO
1032	ICD SIXTH SURGICAL PROCEDURE IS NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M67	Missing/incomplete/invalid other procedure code(s). (Modified 12/2/04) Related to N302	CO
1033	SURGERY DATE IS NOT WITHIN FROM AND TO DATE SPAN	181	Payment adjusted because this procedure code was invalid on the date of service	N341	Missing/incomplete/invalid surgery date.	CO
1043	RENDERING PROVIDER LICENSE EXPIRED	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	N59	Please refer to your provider manual for additional program and provider information.	CO
1046	OTHER PROVIDER 1 OR 2 NOT ENROLLED IN HOSPICE SERVICE WHEN LTC MEMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N270	Missing/incomplete/invalid other provider primary identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1047	GBHC REFERRAL UNITS HAVE BEEN EXHAUSTED	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M62	Missing/incomplete/invalid treatment authorization code.	CO
1050	SERVICE NOT REFERRED BY PRIMARY CARE CASE MANAGER	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M62	Missing/incomplete/invalid treatment authorization code.	CO
1052	DEPT OF HEALTH LICENSE NUMBER IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO
1055	DTL REFERRING PROV NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N286	Missing/incomplete/invalid referring provider primary identifier.	CO
1058	NO PAY TO PROVIDER RECORD FOR CROSSOVER CLAIM	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N280	Missing/incomplete/invalid pay-to provider primary identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1060	GBHC REFERRAL NUMBER IS MISSING OR INVALID	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
1062	FIRST SURGICAL PROCEDURE INVALID FOR MEMBER SEX	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
1063	SECOND SURGICAL PROCEDURE INVALID FOR MEMBER SEX	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
1064	THIRD SURGICAL PROCEDURE INVALID FOR MEMBER SEX	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
1065	FOURTH SURGICAL PROCEDURE INVALID FOR MEMBER SEX	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
1066	FIFTH SURGICAL PROCEDURE INVALID FOR MEMBER SEX	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
1067	SIXTH SURGICAL PROCEDURE INVALID FOR MEMBER SEX	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
1069	TRADING PARTNER NOT AUTH TO BILL FOR BILLING PROV	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N521	Mismatch between the submitted provider information and the provider information stored in our system.	CO
1070	FIRST SURGICAL PROCEDURE CODE IS INVALID	181	Payment adjusted because this procedure code was invalid on the date of service	M67	Missing/incomplete/invalid other procedure code(s). (Modified 12/2/04) Related to N302	CO
1071	2ND SURGICAL PROCEDURE OR DATE IS INVALID	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
1073	4TH SURGICAL PROCEDURE NOT FOUND	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
1074	5TH SURGICAL PROCEDURE NOT FOUND	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
1076	PROVIDER LICENSURE INDICATOR NOT POPULATED	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1077	MEMBER IS UNDER REVIEW. POSSIBLE PA FOR TRANSPLANT SERVICE	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
1079	DIAGNOSIS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1080	MEMBER SEX ON FILE INCOMPATIBLE W/PRIMARY DIAG	10	The diagnosis is inconsistent with the patient's gender.	N59	Please refer to your provider manual for additional program and provider information.	CO
1081	SECOND DIAGNOSIS CODE INVALID FOR MEMBER SEX	10	The diagnosis is inconsistent with the patient's gender.	N59	Please refer to your provider manual for additional program and provider information.	CO
1082	THIRD DIAGNOSIS CODE INVALID FOR MEMBER SEX	10	The diagnosis is inconsistent with the patient's gender.	N59	Please refer to your provider manual for additional program and provider information.	CO
1083	FOURTH DIAGNOSIS CODE INVALID FOR MEMBER SEX	10	The diagnosis is inconsistent with the patient's gender.	N59	Please refer to your provider manual for additional program and provider information.	CO
1084	FIFTH DIAGNOSIS CODE INVALID FOR MEMBER SEX	10	The diagnosis is inconsistent with the patient's gender.	N59	Please refer to your provider manual for additional program and provider information.	CO
1085	PSN CLAIM REQUIRES REVIEW OR IS NOT AUTHORIZED BY PSN	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N35	Program integrity/utilization review decision.	CO
1087	NURSING HOME PROVIDER NOT ELIGIBLE TO PROVIDE SERVICE TO MEMBER ON DOS	185	The rendering provider is not eligible to perform the service billed.	N30	Patient ineligible for this service.	CO
1088	MEMBER INELIGIBLE FOR NURSING HOME ON DATE OF SERVICE	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
1089	AN ATTENDING PROVIDER ID IS REQUIRED WHEN BILLING REVENUE CODE 657	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N253	Missing/incomplete/invalid attending provider primary identifier.	CO
1090	1ST SURGICAL PROCEDURE DATE IS MISSING OR ZEROS	181	Payment adjusted because this procedure code was invalid on the date of service	N341	Missing/incomplete/invalid surgery date.	CO
1091	2ND SURGICAL PROCEDURE DATE IS MISSING OR ZEROS	181	Payment adjusted because this procedure code was invalid on the date of service	N341	Missing/incomplete/invalid surgery date.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1092	3RD SURGICAL PROCEDURE DATE IS MISSING OR ZEROS	181	Payment adjusted because this procedure code was invalid on the date of service	N341	Missing/incomplete/invalid surgery date.	CO
1093	4TH SURGICAL PROCEDURE DATE IS MISSING OR ZEROS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N341	Missing/incomplete/invalid surgery date.	CO
1094	5TH SURGICAL PROCDURE DATE IS MISSING OR ZEROS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N341	Missing/incomplete/invalid surgery date.	CO
1095	6TH SURGICAL PROCEDURE DATE IS MISSING OR ZEROS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N341	Missing/incomplete/invalid surgery date.	CO
1096	OCCUR SPAN TO DATE IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N300	Missing/incomplete/invalid occurrence span date(s).	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1097	OCCUR SPAN FROM DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N300	Missing/incomplete/invalid occurrence span date(s).	CO
1098	MISSING OCCURRENCE SPAN CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M46	Missing/incomplete/invalid occurrence span code(s). (Modified 12/2/04) Related to N300	CO
1099	OCCUR SPAN FROM DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N300	Missing/incomplete/invalid occurrence span date(s).	CO
1100	REFERRING PROVIDER NUMBER REQUIRED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N286	Missing/incomplete/invalid referring provider primary identifier.	CO
1102	NURSING HOME PROVIDER NOT ALLOWED TO BILL REVENUE CODES	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N95	This provider type/provider specialty may not bill this service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1103	MID-MONTH RATE CHANGE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N144	The rate changed during the dates of service billed.	CO
1107	ICD PROCEDURE RESTRICTION FOR BILLED PROCEDURE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M50	Missing/incomplete/invalid revenue code(s).	CO
1110	THE PROVIDER IS NOT AUTHORIZED BY THE NURSING HOME SPAN FOR THIS	171	Payment is denied when performed/billed by this type of provider in this type of facility.	MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.	CO
1112	CLAIM DENIED. UNABLE TO DETERMINE COS WITHIN 90 DAYS. CORRECT CLAIM AN	164	Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion.	N223	Missing documentation of benefit to the patient during initial treatment period.	CO
1113	CLAIM DENIED. UNABLE TO DETERMINE COS WITHIN 90 DAYS. CORRECT CLAIM AN	164	Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion.	N223	Missing documentation of benefit to the patient during initial treatment period.	CO
1130	OCCUR SPAN 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. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N300	Missing/incomplete/invalid occurrence span date(s).	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1131	INVALID PROVIDER SPECIALTY FOR REVENUE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N95	This provider type/provider specialty may not bill this service.	CO
1132	DATE PRESCRIBED IS AFTER BILLING DATE	110	Billing date predates service date.	N57	Missing/incomplete/invalid prescribing date. (Modified 12/2/04) Related to N304	CO
1134	MEDICARE PART B COVERS SOME SERVICES RENDERED IN AN INPATIENT SETTING.	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO
1136	PRIMARY DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS	9	The diagnosis is inconsistent with the patient's age.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1137	SECOND DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS	9	The diagnosis is inconsistent with the patient's age.	M64	Missing/incomplete/invalid other diagnosis.	CO
1138	THIRD DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS	9	The diagnosis is inconsistent with the patient's age.	M64	Missing/incomplete/invalid other diagnosis.	CO
1139	FOURTH DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS	9	The diagnosis is inconsistent with the patient's age.	M64	Missing/incomplete/invalid other diagnosis.	CO
1140	FIFTH DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS	9	The diagnosis is inconsistent with the patient's age.	M64	Missing/incomplete/invalid other diagnosis.	CO
1144	INVALID HOSPITALIST CLAIM	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N34	Incorrect claim form/format for this service.	CO
1145	FIRST DIAGNOSIS CODE NOT COVERED	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1146	SECOND DIAGNOSIS NOT COVERED	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1147	THIRD DIAGNOSIS CODE NOT COVERED	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
1148	FOURTH DIAGNOSIS CODE NOT COVERED	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
1149	FIFTH DIAGNOSIS CODE NOT COVERED	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
1150	MODIFIER 80 REQUIRED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N519	Invalid combination of HCPCS modifiers.	CO
1152	CREDIT OR REPLACEMENT TCN IS MISSING OR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M47	Missing/incomplete/invalid internal or document control number.	CO
1153	MEMBER ID NUMBER NOT ON FILE	140	Patient/Insured health identification number and name do not match.	N382	Missing/incomplete/invalid patient identifier.	CO
1154	THE RENDERING PROVIDER DOES NOT MATCH RENDERING PROVIDER ON CLAIM THAT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N290	Missing/incomplete/invalid rendering provider primary identifier.	CO
1155	CLAIM HAS ALREADY BEEN CREDITED/ADJUSTED/REPLACED	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	N377	Payment adjusted based on a processed replacement claim.	CO
1156	REPLACEMENT OR CREDIT OF A DENIED CLAIM	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	N152	Missing/incomplete/invalid replacement claim information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1157	CLAIM NOT FOUND ON HISTORY	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	N517	Resubmit a new claim with the requested information.	CO
1158	A CREDIT CANNOT BE ADJUSTED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA67	Correction to a prior claim.	CO
1160	EDIT SET TO PAY AND REPORT DUE TO SYSTEMS ISSUES, THE CLAIM WILL BE RE	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	N59	Please refer to your provider manual for additional program and provider information.	CO
1169	SIXTH DIAGNOSIS CODE NOT COVERED	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
1170	FIRST SURGICAL PROCEDURE NOT COVERED	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
1171	SECOND SURGICAL PROCEDURE NOT COVERED	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
1172	THIRD SURGICAL PROCEDURE NOT COVERED	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
1173	FOURTH SURGICAL PROCEDURE NOT COVERED	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
1174	FIFTH SURGICAL PROCEDURE NOT COVERED	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
1175	SIXTH SURGICAL PROCEDURE NOT COVERED	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
1176	FIRST SURGICAL PROCEDURE NOT BILLED	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
1177	SECOND SURGICAL PROCEDURE NOT BILLED	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
1178	THIRD SURGICAL PROCEDURE NOT BILLED	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
1179	FOURTH SURGICAL PROCEDURE NOT BILLED	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1180	FIFTH SURGICAL PROCEDURE NOT BILLED	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
1181	SIXTH SURGICAL PROCEDURE NOT BILLED	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
1182	FIRST DIAGNOSIS CODE NOT BILLED	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
1183	SECOND DIAGNOSIS NOT BILLED	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
1184	THIRD DIAGNOSIS CODE NOT BILLED	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
1185	FOURTH DIAGNOSIS CODE NOT BILLED	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
1186	FIFTH DIAGNOSIS CODE NOT BILLED	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
1187	SIXTH DIAGNOSIS CODE NOT BILLED	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
1201	PAY TO PROVIDER IS INACTIVE. CONTACT PROVIDER ENROLLMENT FOR INSTRUCTI	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N280	Missing/incomplete/invalid pay-to provider primary identifier.	CO
1202	X-OVER CLAIM TYPE NOT ALLOWED FOR PROVIDER TYPE	170	Payment is denied when performed/billed by this type of provider.	N95	This provider type/provider specialty may not bill this service.	CO
1230	PART B INPATIENT CLAIMS REVIEW	229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey COB information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer.	N374	Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required.	PR
1236	MEMBER COUNTY RESTRICTION FOR BILLED PROCEDURE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N79	Service billed is not compatible with patient location information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1237	ICD PROCEDURE RESTRICTION FOR BILLED REVENUE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M50	Missing/incomplete/invalid revenue code(s).	CO
1238	FRACTIONAL UNITS ALLOWED ONLY FOR SPECIFIC COS	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA30	Missing/incomplete/invalid type of bill.	CO
1245	SUPERSUSPEND QMB DENIALS FOR DISPO UPDATE REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
1246	SUPERSUSPEND QMB DENIALS FOR DISPO UPDATE REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
1257	FREQUENCY CODE 6 IS NOT ALLOWED	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N431	Service is not covered with this procedure.	CO
1303	MAMMOGRAPHY PERFORMED OUTSIDE OF CERTIFICATION DATES	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N474	Incomplete/invalid certification	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1304	MAMMOGRAPHY CERTIFICATION NUMBER MISSING OR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N474	Incomplete/invalid certification	CO
1306	RENDERING PROVIDER OUT OF STATE - CLAIM SUSPENDED FOR REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
1353	MENTAL HEALTH SVC NOT COVERED IN NURSING HOME	5	The procedure code/bill type is inconsistent with the place of service.	N428	Service/procedure not covered when performed in this place of service.	CO
1354	VENT PA TYPE MISSING OR INVALID	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
1374	ATTACHMENT REQUIRES MANUAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
1375	SPECIAL PROCESSING ATTACHMENT REQUIRES REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
1385	PATIENT REASON DIAGNOSIS INVALID	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
1400	1ST ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1401	2ND ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1402	3RD ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1403	4TH ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1404	5TH ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1405	6TH ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1406	7TH ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1407	8TH ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1408	9TH ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1409	10TH-25TH ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1410	1ST ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1411	2ND ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1412	3RD ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1413	4TH ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1414	5TH ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1415	6TH ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1416	7TH ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1417	8TH ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1418	9TH ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1419	10TH-12TH ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1420	1ST ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1421	2ND ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1422	3RD ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1423	4TH ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1424	5TH ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1425	6TH ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1426	7TH ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1427	8TH ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1428	9TH ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1429	10TH-25TH ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1430	1ST ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1431	2ND ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1432	3RD ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1433	4TH ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1434	5TH ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1435	6TH ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1436	7TH ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1437	8TH ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1438	9TH ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1439	10TH-12TH ICD-10 DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
1600	INVALID GROUP NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M112	The approved amount is based on the maximum allowance for this item under the DMEPOS Competitive Bidding Demonstration.	CO
1601	TPL IS INDICATED ON FILE, BUT DID NOT APPEAR ON CLAIM. YOUR CLAIM WAS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO
1603	PROVIDER NOT AUTHORIZED TO TAPE BILL	170	Payment is denied when performed/billed by this type of provider.	N95	This provider type/provider specialty may not bill this service.	CO
1770	INPATIENT PART-B CLAIMS REQUIRE AN EOB ATTACHMENT AND/OR EXHAUSTION OF BENEFIT	163	Claim/Service adjusted because the attachment referenced on the claim was not received.	N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1771	INPATIENT PART-B CLAIMS REQUIRE A VALID PART-B (MB) PRIOR PAYMENT AMOUNT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO
1772	INPATIENT PART-B CLAIMS REQUIRE A VALID MEDICAID (MC) PRIOR PAYMENT AMOUNT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO
1773	OUTPATIENT CROSSOVER CLAIM HAS NOT ADJUDICATED THROUGH MEDICAID?S SYSTEM. SUBMI	228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication.	N36	Claim must meet primary payer�s processing requirements before we can consider payment.	CO
1774	ONE OF THE FOLLOWING ATTACHMENTS IS MISSING:MEDICARE PART B EOMB FOR DOS OR EXH	163	Claim/Service adjusted because the attachment referenced on the claim was not received.	N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	CO
1775	DOS ON CLAIM DOES NOT MATCH DOS ON EOMB	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1776	MEDICARE PAYMENT (MB) DOES NOT AGREE WITH EOB	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N4	Missing/incomplete/invalid prior insurance carrier EOB.	CO
1777	MEDICAID PAYMENT (MC) DOES NOT AGREE WITH CLAIM ON RECORD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO
1800	PROVIDER SPECIALTY 701/702/703 - HDR	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1801	PROVIDER SPECIALTY 701/702/703 for Dtl DOS	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1802	CLAIM REQUIRES REFER AND/OR ATTEND PROVIDER	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1803	DTL REFER 1 PROV NPI NOT IN MMIS	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1804	DTL REFER 1 PROV NOT ACTIVE/ELIGIBLE	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1805	DTL REFER 1 PROV CANNOT ORDER/REFER/PRESCRIBE	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1806	HDR REFER 1 PROV NPI NOT IN MMIS - DTL	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1807	HDR REFER 1 PROV NPI NOT IN MMIS - HDR	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1808	HDR REFER 1 PROV NOT ACTIVE/ELIGIBLE - DTL	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1809	HDR REFER 1 PROV NOT ACTIVE/ELIGIBLE - HDR	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1810	HDR REFER 1 PROV CANNOT ORDER/REFER/PRESCRIBE- DTL	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1811	HDR REFER 1 PROV CANNOT ORDER/REFER/PRESCRIBE- HDR	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1812	DTL REFER 2 PROV NPI NOT IN MMIS	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1813	DTL REFER 2 PROV NOT ACTIVE/ELIGIBLE	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1814	DTL REFER 2 PROV CANNOT ORDER/REFER/PRESCRIBE	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1815	HDR REFER 2 PROV NPI NOT IN MMIS - DTL	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1816	HDR REFER 2 PROV NOT ACTIVE/ELIGIBLE - DTL	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1817	HDR REFER 2 PROV CANNOT ORDER/REFER/PRESCRIBE- DTL	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1818	HDR ATTEND 1 PROV NPI NOT IN MMIS - DTL	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1819	HDR ATTEND 1 PROV NPI NOT IN MMIS - HDR	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1820	HDR ATTEND 1 PROV NOT ACTIVE/ELIGIBLE - DTL	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1821	HDR ATTEND 1 PROV NOT ACTIVE/ELIGIBLE - HDR	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1822	HDR ATTEND 1 PROV CANNOT ORDER/REFER/PRESCRIBE-DTL	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1823	HDR ATTEND 1 PROV CANNOT ORDER/REFER/PRESCRIBE-HDR	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1824	DTL OTHER 1 PROV NPI NOT IN MMIS	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1825	DTL OTHER 1 PROV NOT ACTIVE/ELIGIBLE	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1826	DTL OTHER 1 PROV CANNOT ORDER/REFER/PRESCRIBE	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1827	HDR REFER 2 PROV NPI NOT IN MMIS - HDR	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1828	HDR REFER 2 PROV NOT ACTIVE/ELIGIBLE - HDR	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1829	HDR REFER 2 PROV CANNOT ORDER/REFER/PRESCRIBE- HDR	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1840	ENCOUNTER ATTENDING PROVIDER NBR/NPI NOT ON FILE -HDR	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1841	ENC ATTENDING PROVIDER NBR/NPI NOT ON FILE - DTL	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1842	ENC ORDERING PROVIDER NBR/NPI NOT ON FILE - HDR	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1843	ENC ORDERING PROVIDER NBR/NPI NOT ON FILE - DTL	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1844	ENC PROV CANNOT ORDER/REFER/PRESCRIBE - HDR	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1845	ENC PROV CANNOT ORDER/REFER/PRESCRIBE - DTL	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1846	ENC UB REQUIRES REFER AND/OR ATTEND PROV - ALWAYS	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1847	ENC UB REQUIRES REFER AND/OR ATTEND PROV - SOMETIMES	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1848	ENC DENTAL REQUIRES REFER PROV	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1849	PROF REQUIRES REFER OR ORDERING PROV - HDR ALWAYS	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1850	PROF REQUIRES REFER OR ORDERING PROV - HDR SOMETIMES	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1851	PROF REQUIRES REFER OR ORDERING PROV - DTL ALWAYS	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1852	PROF REQUIRES REFER OR ORDERING PROV - DTL SOMETIMES	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1896	ENCOUNTER REFERRING PROVIDER NUMBER OR NPI NOT ON FILE - HDR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N237	Incomplete/invalid patient medical record for this service.	CO
1897	ENCOUNTER REFERRING PROVIDER NUMBER OR NPI NOT ON FILE - DTL	242	Services not provided by network/primary care providers.	N237	Incomplete/invalid patient medical record for this service.	CO
1898	ENCOUNTER INSTITUTIONAL PROVIDER NUMBER OR NPI NOT ON FILE - DTL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N237	Incomplete/invalid patient medical record for this service.	CO
1899	ENCOUNTER PROVIDER NUMBER OR NPI NOT ON FILE	208	NPI denial - not matched. This change to be effective 4/1/2008: National Provider Identifier - Not matched.	N237	Incomplete/invalid patient medical record for this service.	CO
1901	ABORTION CERTIFICATE INVALID	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N255	Missing/incomplete/invalid billing provider taxonomy.	CO
1902	CONSENT FORM MISSING	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N3	Missing consent form. (Modified 2/28/03) Related to N228	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1903	CONSENT FORM INCOMPLETE	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N228	Incomplete/invalid consent form.	CO
1904	CONSENT FORM INVALID	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N228	Incomplete/invalid consent form.	CO
1905	ACKNOWLEDGEMENT FORM MISSING	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	CO
1906	ACKNOWLEDGEMENT FORM INVALID/INCOMPLETE	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	CO
1907	INCIDENTAL PROCEDURE NOT COVERED	181	Payment adjusted because this procedure code was invalid on the date of service	N356	This service is not covered when performed with, or subsequent to, a non-covered service.	CO
1908	PROCEDURE REQUIRES REVIEW REPORT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N35	Program integrity/utilization review decision.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1909	CLAIM REQUIRES DOCUMENTATION	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	CO
1910	PROCEDURE CODE/DESCRIPTION CONFLICT	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
1912	PROF CLAIM REQUIRES REFER AND/OR ORDER PROVIDER	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1913	DENTAL CLAIM REQUIRES REFER PROVIDER	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
1929	NPI REQUIRED - REFERRING PROVIDER HEALTHCARE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N433	Resubmit this claim using only your National Provider Identifier (NPI)	CO
1932	NPI REQUIRED - OTHER PROVIDER 2 - HEALTHCARE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N433	Resubmit this claim using only your National Provider Identifier (NPI)	CO
1933	NPI REQUIRED - DTL OTHER PROVIDER 2 HEALTHCARE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N433	Resubmit this claim using only your National Provider Identifier (NPI)	CO
1937	PERFORMING PROVIDER ID NOT ON FILE	185	The rendering provider is not eligible to perform the service billed.	N290	Missing/incomplete/invalid rendering provider primary identifier.	CO
1938	REFERRING PROVIDER NUMBER IS MISSING OR INVALID	38	Services not provided or authorized by designated (network/primary care) providers.	N286	Missing/incomplete/invalid referring provider primary identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1940	INVALID RENDERING PROVIDER OVERRIDE SPECIFIED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N290	Missing/incomplete/invalid rendering provider primary identifier.	CO
1941	OTHER PROVIDER ID NOT ON FILE	148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.	N207	Missing/incomplete/invalid weight.	OA
1944	INVALID DTL REFERRING PROVIDER OVERRIDE SPECIFIED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N79	Service billed is not compatible with patient location information.	CO
1945	MULTIPLE SERVICE LOCATIONS FOR BILLING PROVIDER	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N93	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.	CO
1947	MULTIPLE SERVICE LOCATIONS FOR REFERRING PROVIDER	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N93	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.	CO
1949	MULTIPLE SERVICE LOCATIONS FOR RENDERING PROVIDER	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N93	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.	CO
1950	MULTIPLE SERVICE LOCATIONS FOR OTHER PROVIDER 2	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N93	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1951	MULTIPLE SERVICE LOCS FOR DTL OTHER PROVIDER 2	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N93	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.	CO
1953	MULTIPLE SERVICE LOCS FOR DTL REFERRING PROVIDER	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N93	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.	CO
1954	ENCOUNTER TAXONOMY CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.	CO
1955	NPI IS REQUIRED ON HEALTHCARE ENCOUNTER CLAIM	206	NPI denial - Missing. This change to be effective 4/1/2008: National Provider Identifier - missing.	N433	Resubmit this claim using only your National Provider Identifier (NPI)	CO
1956	TAXONOMY CODE IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.	CO
1994	RENDERING PROVIDER ID NOT ELIGIBLE FOR CLAIMS SUBMISSION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N282	Missing/incomplete/invalid pay-to provider secondary identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
1995	RENDER\DISPENS\PERFORM PROV ID IN OLD FORMAT - HDR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N290	Missing/incomplete/invalid rendering provider primary identifier.	CO
1998	NO MATCH FOR THE NPI NUMBER SUBMITTED ON CLAIM	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M56	Missing/incomplete/invalid payer identifier.	CO
2000	MEMBER HAS OPTED OUT OF MEDICAID COVERAGE	100	Payment made to patient/insured/responsible party.	N59	Please refer to your provider manual for additional program and provider information.	OA
2001	SURGICAL PROCEDURE CONFLICTS WITH AGE LIMITATIONS	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
2002	MEMBER NOT ELIGIBLE FOR HEADER DATE OF SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
2003	MEMBER INELIGIBLE ON DETAIL DATE OF SERVICE	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
2004	PROCEDURE INCLUDED IN COMBINED PROCEDURE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
2008	EXCEEDS EMERGENCY ROOM VISITS FOR THIS DATE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
2009	MEMBER INELIGIBLE ON DATE OF SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2010	NEWBORN OCCURRENCE CODE MISSING. WHEN ADMIT AND BIRTH DATES ARE EQUAL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N299	Missing/incomplete/invalid occurrence date(s).	CO
2011	MATERNITY CLINIC/PHY CONFLICT FOR PRENATAL SERVICE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2012	MAXIMUM CRITICAL CARE VISITS EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2013	EXCEEDS 9 MO LIMIT FOR THIS LEVEL PRENATAL CARE	119	Benefit maximum for this time period or occurrence has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
2014	EXCEEDS MONTHLY CLINIC VISIT LIMITS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
2015	SCHOOL BASED YEARLY LIMIT EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
2016	LIMIT OF HH VISITS HAS BEEN EXCEEDED FOR 1 YEAR	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2018	DIABETIC SUPPLIES LIMITS EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2019	PROFESSIONAL SERVICE BILLED THOUGH MEMBER ENROLLED IN CMO ON DOS	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N59	Please refer to your provider manual for additional program and provider information.	CO
2020	YEARLY LIMIT FOR EYE GLASSES EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
2021	MEMBER IS ENROLLED IN A CMO - CARE MANAGEMENT ORGANIZATION	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	N59	Please refer to your provider manual for additional program and provider information.	OA
2022	A CONFLICTING SERVICE HAS BEEN PAID FOR THIS DATE	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2023	DEALER LIMITS EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
2024	OTHER FED QUAL HEALTH CENTER SERV PAID THIS DATE	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N131	Total payments under multiple contracts cannot exceed the allowance for this service.	OA
2025	EXCEEDS EARLY INTERVENTION SERVICES LIMITS	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2026	EXCEEDS EPSDT CLINIC LIMITS	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2027	EXCEEDS OB ULTRASOUND LIMIT FOR 9 MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
2028	EXCEEDS NUTRITIONAL SERVICE FOR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2029	EXCEEDS HOME COM BASED WAIVERED SERVICE LIMITS	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2030	SAME SERV WITH 91/92 HCPC HAS BEEN PAID THIS DATE	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
2031	HOSPICE CLAIM SPANS A MEMBER HOSPICE SEGMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N30	Patient ineligible for this service.	CO
2032	CLAIM SPANS A MEMBER HOSPICE SEGMENT	B9	Services not covered because the patient is enrolled in a Hospice.	N30	Patient ineligible for this service.	CO
2034	EXCEEDS YEARLY EARLY INTERVENTION CASE MAN LIMITS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
2035	THE 2 PHY VISIT PER MONTH LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2036	ADDITIONAL HOURS OF TESTING REQUIRE PRIOR AUTHORIZATION	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N435	Exceeds number/frequency approved /allowed within time period without support documentation.	CO
2037	MAXIMUM PAYMENT MADE	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2038	EXCEEDS OXYGEN LIMITS-ONE PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
2039	TARGETED ULTRASOUND/AMNIOCENTISIS REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
2040	THE MAMMOGRAM LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2044	CLAIM INDICATES MEMBER EXPIRED	13	The date of death precedes the date of service.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
2046	RESPITE SERVICE NOT COVERED IN NURSING HOME	100	Payment made to patient/insured/responsible party.	N59	Please refer to your provider manual for additional program and provider information.	OA
2048	CONFLICTING DENTAL SERVICE SAME DAY	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
2049	EXCEEDS PSYCHOLOGICAL LIMIT PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2050	EXCEPTION CODE 050	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
2064	CLAIM DOS/MEMBER DATE OF DEATH CONFLICT	13	The date of death precedes the date of service.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
2070	2 NURSING HOME VISITS PREVIOUSLY PAID THIS MONTH	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
2071	THIS SERV HAS BEEN PREVIOUSLY PAID FOR THIS MEMBER	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2072	PREVIOUSLY PAID VISUAL EXAM IN 12 MONTHS	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
2091	MEMBER SERVICES COVERED BY CMO PLAN	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	MA73	Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.	OA
2092	THE DIALYSIS FACILITY MUST SUBMIT THE ESRD ENROLLMENT FORM SINCE THIS	150	Payment adjusted because the payer deems the information submitted does not support this level of service.	N30	Patient ineligible for this service.	CO
2094	PROVIDER SPECIALTY REQUIRES THE BENEFICIARY BE ELIGIBLE FOR WAIVER REL	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	N95	This provider type/provider specialty may not bill this service.	CO
2095	PATIENT LIABILITY SEGMENT NOT ON FILE FOR MEMBER - SUSPEND FOR REVIEW	142	Claim adjusted by the monthly Medicaid patient liability amount.	N58	Missing/incomplete/invalid patient liability amount.	PR
2096	PATIENT LIABILITY SEGMENT NOT ON FILE FOR MEMBER - CLAIM DENIED	142	Claim adjusted by the monthly Medicaid patient liability amount.	N58	Missing/incomplete/invalid patient liability amount.	PR
2097	COVERED IN PER DIEM	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
2100	MEMBER INELIGIBLE FOR MEDICAID ONLY SERVICES	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
2103	PROCEDURE NOT COVERED WITH THIS PLACE OF SERVICE	5	The procedure code/bill type is inconsistent with the place of service.	N428	Service/procedure not covered when performed in this place of service.	CO
2104	INVALID PROVIDER SPECIALTY FOR PROCEDURE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N95	This provider type/provider specialty may not bill this service.	CO
2105	INVALID DIAGNOSIS FOR PROCEDURE	11	The diagnosis is inconsistent with the procedure.	MA63	Missing/incomplete/invalid principal diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2110	MEMBER INELIGIBLE ON DATE OF SERVICE	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
2112	MISSING TOTAL CHARGE FOR NURSING HOME CLAIM	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	M54	Missing/incomplete/invalid total charges.	CO
2118	DISCHARGE DATE IS LESS THAN ADMIT DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N318	Missing/incomplete/invalid discharge or end of care date.	CO
2119	DISCHARGE DATE IS LESS THAN LAST DATE OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N318	Missing/incomplete/invalid discharge or end of care date.	CO
2120	VISIT PAID IN NORMAL SURGERY FOLLOW-UP PERIOD	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	OA
2121	CLAIM WAS FILED WITHOUT SERVICING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N283	Missing/incomplete/invalid purchased service provider identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2122	INVALID/MISSING PROVIDER CHECK-DIGIT NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO
2123	INVALID/MISSING PAY-TO PROVIDER CHECK-DIGIT NUMBER	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N280	Missing/incomplete/invalid pay-to provider primary identifier.	CO
2124	MISSING FIRST DATE OF SERVICE ON CLAIM	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M52	Missing/incomplete/invalid 'from' date(s) of service.	CO
2125	ONE YEAR TIMELY FILING DEADLINE EXCEEDED-FED REG	29	The time limit for filing has expired.	N59	Please refer to your provider manual for additional program and provider information.	CO
2126	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. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M52	Missing/incomplete/invalid 'from' date(s) of service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2127	BILLING PT/PS RESTRICTION FOR COVERED ICD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N95	This provider type/provider specialty may not bill this service.	CO
2128	DATE OF ACCIDENT IS INVALID	110	Billing date predates service date.	N305	Missing/incomplete/invalid accident date.	CO
2130	DETAIL FDOS IS OUTSIDE HEADER FROM/TO DATES	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M52	Missing/incomplete/invalid 'from' date(s) of service.	CO
2135	TRANSFER OF RESOURCES PENALTY INDICATED	100	Payment made to patient/insured/responsible party.	N59	Please refer to your provider manual for additional program and provider information.	OA
2140	INVALID REV CODE - PROCEDURE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA50	Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.	CO
2143	MAXIMUM NUMBER OF REFILLS HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
2144	REFILL INDICATOR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N378	Missing/incomplete/invalid prescription quantity.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2151	PRESCRIBING PRACTITIONERS LICENSE NUMBER MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N31	Missing/incomplete/invalid prescribing provider identifier.	CO
2153	NDC IS NOT NUMERIC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
2154	PRESCRIPTION NUMBER IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N388	Missing/incomplete/invalid prescription number	CO
2160	MISSING DIAGNOSIS INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO
2168	SOURCE OF ADMISSION MISSING OR INVALID	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA42	Missing/incomplete/invalid admission source.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2178	PROCEDURE REQUIRES PRIOR AUTHORIZATION	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
2179	MISSING TOOTH SURFACE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N75	Missing/incomplete/invalid tooth surface information.	CO
2180	INVALID TOOTH NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N37	Missing/incomplete/invalid tooth number/letter.	CO
2181	INVALID TOOTH SURFACE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N75	Missing/incomplete/invalid tooth surface information.	CO
2182	MISSING TOOTH NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N37	Missing/incomplete/invalid tooth number/letter.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2183	MISSING UNITS OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M53	Missing/incomplete/invalid days or units of service.	CO
2184	MISSING CHARGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO
2185	LTC MISSING ADMISSION DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA40	Missing/incomplete/invalid admission date.	CO
2186	INVALID ADMISSION HOUR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N46	Missing/incomplete/invalid admission hour.	CO
2187	PROCEDURE NOT PAYABLE THIS MEMBER	204	This service/equipment/drug is not covered under the patient&#65533;s current benefit plan	N30	Patient ineligible for this service.	CO
2189	PROCEDURE REQUIRES MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2190	PROCEDURE REQUIRES PRIOR AUTHORIZATION	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
2191	COVERED DAYS EXCEED STATEMENT PERIOD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA32	Missing/incomplete/invalid number of covered days during the billing period.	CO
2192	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. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N345	Date range not valid with units submitted.	CO
2193	MISSING COVERED DAYS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA32	Missing/incomplete/invalid number of covered days during the billing period.	CO
2194	AGE IS NOT COVERED INPATIENT PSYCHIATRIC SERVICES	6	The procedure/revenue code is inconsistent with the patient's age.	N59	Please refer to your provider manual for additional program and provider information.	CO
2196	MISSING ADMISSION DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA40	Missing/incomplete/invalid admission date.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2197	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. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M50	Missing/incomplete/invalid revenue code(s).	CO
2198	MISSING ATTENDING SURGEON PROVIDER NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N253	Missing/incomplete/invalid attending provider primary identifier.	CO
2199	DATE OF SURGERY IS MISSING OR ZEROS	181	Payment adjusted because this procedure code was invalid on the date of service	N341	Missing/incomplete/invalid surgery date.	CO
2200	TYPE OF ADMISSION IS MISSING OR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA41	Missing/incomplete/invalid admission type.	CO
2201	PROCEDURE CODE IS NOT IN THE SCOPE OF PROGRAM	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N188	The approved level of care does not match the procedure code submitted.	CO
2202	SUB TYPE REQUIRED FOR THIS DIAGNOSIS CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2203	RENDERING PROVIDER SIGNATURE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA70	Missing/incomplete/invalid provider representative signature.	CO
2209	INVALID DESTINATION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N517	Resubmit a new claim with the requested information.	CO
2214	DATE PRESCRIBED IS INVALID	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N57	Missing/incomplete/invalid prescribing date. (Modified 12/2/04) Related to N304	CO
2215	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. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N304	Missing/incomplete/invalid dispensed date.	CO
2216	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. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N304	Missing/incomplete/invalid dispensed date.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2222	MISSING OCCURRENCE DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M45	Missing/incomplete/invalid occurrence code(s). (Modified 12/2/04) Related to N299	CO
2223	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. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N351	Service date outside of the approved treatment plan service dates.	CO
2224	INVALID OCCURRENCE DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N299	Missing/incomplete/invalid occurrence date(s).	CO
2228	MISSING MEDICARE PAID DATE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N307	Missing/incomplete/invalid adjudication or payment date.	CO
2230	NO CROSSOVER COINSURANCE OR DEDUCTIBLE DUE	2	Coinsurance Amount	N8	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.	PR
2231	DAYS SUPPLY INVALID	154	Payment adjusted because the payer deems the information submitted does not support this day's supply.	N374	Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2233	INSURANCE DENIAL REQUIRED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N4	Missing/incomplete/invalid prior insurance carrier EOB.	CO
2234	PROCEDURE REQUIRES PRIOR AUTHORIZATION	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
2235	SURGERY DATE CANNOT BE PRIOR TO ADMIT DATE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N341	Missing/incomplete/invalid surgery date.	CO
2236	SURGERY DATE CANNOT BE OUTSIDE DATE OF SERVICE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N341	Missing/incomplete/invalid surgery date.	CO
2239	INVALID OCCURRENCE SPAN CODE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M46	Missing/incomplete/invalid occurrence span code(s). (Modified 12/2/04) Related to N300	CO
2241	REVIEW ATTACHMENT WHEN MEDICARE CLAIM AMOUNTS ARE ZERO	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO
2242	MISSING OCCURRENCE CODE	129	Payment denied - Prior processing information appears incorrect.	M45	Missing/incomplete/invalid occurrence code(s). (Modified 12/2/04) Related to N299	PI

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2244	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. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N280	Missing/incomplete/invalid pay-to provider primary identifier.	CO
2247	MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N59	Please refer to your provider manual for additional program and provider information.	CO
2249	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. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO
2250	MEMBER IS NOT ON ELIGIBILITY FILE	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
2252	MEMBER HAS PARTIAL ELIGIBLITY FOR DOS. NO BENEFIT PLAN COVERS ALL DATE	239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims. This change effective 11/1/2012: Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	N30	Patient ineligible for this service.	OA
2253	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	M52	Missing/incomplete/invalid 'from' date(s) of service.	CO
2254	MEMBER NOT IN MANAGED CARE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2258	MEMBER IS NOT ON ELIGIBILITY FILE	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
2264	ALIEN REQUIRES CORRECT ATTACHMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
2268	INVALID PER DIEM AMOUNT	147	Provider contracted/negotiated rate expired or not on file.	N59	Please refer to your provider manual for additional program and provider information.	CO
2274	CLAIM INDICATES MEMBER EXPIRED	13	The date of death precedes the date of service.	N59	Please refer to your provider manual for additional program and provider information.	CO
2277	RENDERING PROVIDER NOT MEMBERS LTC PROVIDER	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95	This provider type/provider specialty may not bill this service.	CO
2278	DOCUMENTATION IS NOT PRESENT TO INDICATE AN EMERGENT CONDITION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
2279	ALIEN CLAIM REQUIRES MEDICAL REVIEW SUSPEND TO GMCF	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
2289	PRECERT/PRIOR APPROVAL IS REQUIRED	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2302	ATTENDING PHYSICIAN ID NUMBER NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N253	Missing/incomplete/invalid attending provider primary identifier.	CO
2303	PROVIDER IS SUSPENDED OR TERMINATED FOR PROGRAM BILLED	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N95	This provider type/provider specialty may not bill this service.	CO
2304	PROVIDER INELIGIBLE ON SERVICE DATE	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
2305	REVIEW CLAIMS FOR THIS PROVIDER	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
2306	PAY TO PROVIDER IS SUSPENDED	185	The rendering provider is not eligible to perform the service billed.	N95	This provider type/provider specialty may not bill this service.	CO
2307	BILLING OUT OF CLIA CERTIFICATE TYPE	B23	Payment denied because this provider has failed an aspect of a proficiency testing program.	MA120	Missing/incomplete/invalid CLIA certification number.	CO
2308	NO PAY-TO PROVIDER RECORD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N280	Missing/incomplete/invalid pay-to provider primary identifier.	CO
2309	REVIEW CLAIM FOR PAY-TO-PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N280	Missing/incomplete/invalid pay-to provider primary identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2310	ANESTHESIA MODIFIER IS INVALID OR MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N519	Invalid combination of HCPCS modifiers.	CO
2311	SERVICING PROVIDER IS NOT A MEMBER OF PAY TO GROUP	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N198	Rendering provider must be affiliated with the pay-to provider.	CO
2312	PAY-TO PROVIDER NOT ENROLLED	87	Transfer amount.	N280	Missing/incomplete/invalid pay-to provider primary identifier.	OA
2313	DIAGNOSIS CODE MISSING/NOT ON FILE	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
2314	SURGICAL PROCEDURE CODE NOT FOUND	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M67	Missing/incomplete/invalid other procedure code(s). (Modified 12/2/04) Related to N302	CO
2315	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. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2317	MODIFIER INVALID	182	Payment adjusted because the procedure modifier was invalid on the date of service	N519	Invalid combination of HCPCS modifiers.	CO
2318	PROCEDURE REQUIRES MANUAL PRICING	101	Predetermination: anticipated payment upon completion of services or claim adjudication.	N36	Claim must meet primary payer's processing requirements before we can consider payment.	CO
2319	DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED	168	Payment denied as Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan	N216	Patient is not enrolled in this portion of our benefit package	CO
2320	ICD-10 PROCEDURE NOT SPECIFIC	181	Payment adjusted because this procedure code was invalid on the date of service	N301	Missing/incomplete/invalid procedure date(s).	CO
2321	PROCEDURE CODE IS NO LONGER VALID	181	Payment adjusted because this procedure code was invalid on the date of service	N301	Missing/incomplete/invalid procedure date(s).	CO
2322	DATE OF SERVICE BEFORE PROCEDURE IS PAYABLE	181	Payment adjusted because this procedure code was invalid on the date of service	N301	Missing/incomplete/invalid procedure date(s).	CO
2323	INVALID MEMBER AGE FOR THIS DIAGNOSIS	9	The diagnosis is inconsistent with the patient's age.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
2324	INVALID MEMBER SEX FOR THIS DIAGNOSIS	10	The diagnosis is inconsistent with the patient's gender.	N59	Please refer to your provider manual for additional program and provider information.	CO
2325	NON-COVERED ICD-10 PROCEDURE	181	Payment adjusted because this procedure code was invalid on the date of service	N301	Missing/incomplete/invalid procedure date(s).	CO
2326	INVALID TOOTH NUMBER FOR THIS PROCEDURE	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N39	Procedure code is not compatible with tooth number/letter.	CO
2327	PROCEDURE REQUIRES ADDITIONAL DOCUMENTATION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N29	Missing documentation/orders/notes/summary/report/chart. (Modified 2/28/03, 8/1/05) Related to N225	CO
2328	PROCEDURE NOT IN SCOPE OF PROGRAM FOR THIS AGE	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2329	INVALID MEMBER SEX FOR THIS PROCEDURE	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
2331	THIS DRUG NOT COVERED FOR THE MEMBER	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
2332	INVALID PROVIDER TYPE FOR THIS PROCEDURE	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	N95	This provider type/provider specialty may not bill this service.	CO
2335	LTC MEMBER - NONCOMP DRUG	100	Payment made to patient/insured/responsible party.	N59	Please refer to your provider manual for additional program and provider information.	OA
2336	REFILLS ARE NOT ALLOWED FOR NARCOTIC DRUGS	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N410	This is not covered unless the prescription changes.	CO
2337	THIS DRUG REQUIRES PRIOR AUTHORIZATION	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
2338	LTC DRUG ONLY	100	Payment made to patient/insured/responsible party.	N59	Please refer to your provider manual for additional program and provider information.	OA
2341	THIS DIAGNOSIS REQUIRES MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
2342	THIS DIAGNOSIS REQUIRES MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N59	Please refer to your provider manual for additional program and provider information.	PI
2345	ATTENDING PROVIDER NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N253	Missing/incomplete/invalid attending provider primary identifier.	CO
2346	REFERRING PROVIDER NUMBER NOT ON FILE	183	The referring provider is not eligible to refer the service billed.	N286	Missing/incomplete/invalid referring provider primary identifier.	CO
2347	THIS DIAGNOSIS REQUIRES MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N59	Please refer to your provider manual for additional program and provider information.	PI

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2348	THIS DIAGNOSIS REQUIRES MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N59	Please refer to your provider manual for additional program and provider information.	PI
2350	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. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO
2351	SUBMITTED VS. ALLOWED AMOUNTS EXCEEDS PERCENT	100	Payment made to patient/insured/responsible party.	N59	Please refer to your provider manual for additional program and provider information.	OA
2352	ALLOWED VS. SUBMITTED AMOUNTS EXCEEDS PERCENT	100	Payment made to patient/insured/responsible party.	N59	Please refer to your provider manual for additional program and provider information.	OA
2354	THIS LAB NOT CERTIFIED TO PROVIDE THIS SERVICE	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N428	Service/procedure not covered when performed in this place of service.	CO
2356	NON-COVERED NDC DUE TO CMS TERMINATION	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
2361	PROCEDURE CODE IS MISSING/NOT ON FILE	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
2362	MEDICARE DEDUCTIBLE GREATER THAN MAXIMUM	1	Deductible Amount	N59	Please refer to your provider manual for additional program and provider information.	PR
2366	THIS DIAGNOSIS REQUIRES REVIEW	133	The disposition of this claim/service is pending further review.	N59	Please refer to your provider manual for additional program and provider information.	PI
2369	MEDICARE COINSURANCE GREATER THAN MEDICARE PAID	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N131	Total payments under multiple contracts cannot exceed the allowance for this service.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2371	THIS DIAGNOSIS REQUIRES ADDITIONAL DOCUMENTATION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	CO
2372	ITEM NOT PAYABLE IN LONG TERM CARE FACILITY	100	Payment made to patient/insured/responsible party.	N59	Please refer to your provider manual for additional program and provider information.	OA
2377	MEMBER IS INELIGIBLE FOR THIS DRUG	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
2379	PROCEDURE CODE MODIFIER REQUIRES MANUAL REVIEW	133	The disposition of this claim/service is pending further review.	N59	Please refer to your provider manual for additional program and provider information.	PI
2383	MULTIPLE SURGERY REQUIRES REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
2384	SERVICES NOT ALLOWED ON THE SAME DAY AS TRANS UA	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
2385	REVENUE CODE NOT ON FILE	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M50	Missing/incomplete/invalid revenue code(s).	CO
2386	RENDERING PROVIDER ID NUMBER NOT ON FILE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N59	Please refer to your provider manual for additional program and provider information.	CO
2387	NEW PATIENT VISIT CODE LIMITED TO ONCE EVERY THREE YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
2388	IMPROPER MODIFIER FOR CRNA	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	N519	Invalid combination of HCPCS modifiers.	CO
2389	THIS MODIFIER IS ALLOWED FOR CRNA ONLY	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	N519	Invalid combination of HCPCS modifiers.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2390	MULTIPLE EXTRACTION REQUIRES APPROPRIATE PROC CODE	234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	N431	Service is not covered with this procedure.	CO
2391	INVALID USE OF E DIAGNOSIS CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M64	Missing/incomplete/invalid other diagnosis.	CO
2392	PROCEDURES 92601 AND 92602 CANNOT BE BILLED ON THE SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
2393	PROCEDURES 92603 AND 92604 CANNOT BE BILLED ON THE SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
2414	WAIVER SERVICES LONG TERM CARE CONFLICT	100	Payment made to patient/insured/responsible party.	N59	Please refer to your provider manual for additional program and provider information.	OA
2435	LTC FIRST DATE OF SERVICE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M52	Missing/incomplete/invalid 'from' date(s) of service.	CO
2436	LTC FILING DEADLINE EXCEEDED	29	The time limit for filing has expired.	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2437	LTC FIRST DATE GREATER LAST DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M52	Missing/incomplete/invalid 'from' date(s) of service.	CO
2438	LTC RECHECK SERVICE DATE	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	M52	Missing/incomplete/invalid 'from' date(s) of service.	CO
2439	LTC MISS MEMBER ID NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N382	Missing/incomplete/invalid patient identifier.	CO
2443	LTC MEMBER NOT ON ELIG FILE	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
2444	LTC MEMBER INELIGIBLE ON SERVICE DATES	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30	Patient ineligible for this service.	CO
2445	LTC MEMBER NOT ELIGIBLE ON SERVICE DATES	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30	Patient ineligible for this service.	CO
2446	LTC MEMBER SUSPEND FOR REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
2447	LTC PROV IS SUSPENDED	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
2448	LTC PROVIDER IS INELIGIBLE ON SERVICE DATES	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.	CO
2449	LTC REVIEW CLAIM FOR PROV	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
2451	LTC INV PROVIDER NUMBER	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2452	AUDIT INDUCED HISTORY ADJUSTMENT/VOID	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N19	Procedure code incidental to primary procedure.	OA
2453	INVALID DIAGNOSIS POINTER	147	Provider contracted/negotiated rate expired or not on file.	N27	Missing/incomplete/invalid treatment number.	CO
2454	INVALID ASSIGNMENT CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
2456	INTERIM PAYMENTS CAN NOT BE ADJUSTED THROUGH THE WEB OR EDI	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
2458	ALIEN MEMBER ON REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
2459	CLAIM IS BEING ADJUSTED DUE TO ATP OR NCCI AUDIT	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N19	Procedure code incidental to primary procedure.	OA
2460	CANNOT DETERMINE THE INPATIENT LEVEL OF CARE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N30	Patient ineligible for this service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2461	OCCURENCE CODE SPAN MISSING/INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M46	Missing/incomplete/invalid occurrence span code(s). (Modified 12/2/04) Related to N300	CO
2462	INVALID/MISSING SPAN DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N300	Missing/incomplete/invalid occurrence span date(s).	CO
2463	SPAN THRU DATE LESS THAN SPAN FROM DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N300	Missing/incomplete/invalid occurrence span date(s).	CO
2464	SPAN DATE CONFLICT WITH DATES OF SERVICE SUBMITTED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N300	Missing/incomplete/invalid occurrence span date(s).	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2465	SPAN DATES OVERLAP	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N300	Missing/incomplete/invalid occurrence span date(s).	CO
2466	SPAN DATES DOES NOT EQUAL TOTAL LINE ITEM DAYS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N300	Missing/incomplete/invalid occurrence span date(s).	CO
2468	NAME ON CLAIM MUST MATCH MEDICAID IDENTIFICATION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA36	Missing/incomplete/invalid patient name.	CO
2469	LTC MEMBER NAME/ID MISMATCH	140	Patient/Insured health identification number and name do not match.	N382	Missing/incomplete/invalid patient identifier.	CO
2474	DATE DISPENSED AFTER BILLING DATE	110	Billing date predates service date.	N304	Missing/incomplete/invalid dispensed date.	CO
2476	MAXIMUM HOSPITAL DAYS FOR THIS ADULT HAS BEEN PAID	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2478	PCS MISSING SUBMITTED CHARGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO
2479	CLIA CERTIFICATION IS OUT OF DATE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA120	Missing/incomplete/invalid CLIA certification number.	CO
2485	DATE DISPENSED EARLIER THAN DATE PRESCRIBED	110	Billing date predates service date.	N304	Missing/incomplete/invalid dispensed date.	CO
2486	INPATIENT PSYCHIATRIC NEEDS PRIOR AUTHORIZATION	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
2498	NO HOSPICE LOCKIN AVAILABLE FOR DATES OF SERVICE��	204	This service/equipment/drug is not covered under the patient�s current benefit plan	N30	Patient ineligible for this service.	CO
2502	MEMBER IS MEDICARE ELIGIBLE SO MEDICARE EOMB IS REQUIRED - RESUBMIT WI	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO
2504	MEMBER HAS OTHER INSURANCE COVERAGE ON MEDICAID THIRD PARTY FILE	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO
2505	TPL IS INDICATED ON FILE, BUT DID NOT APPEAR ON CLAIM.	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2507	MEMBER HAS MORE THAN ONE INSURANCE CARRIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO
2510	8TH DIAGNOSIS - AGE CONFLICT FOR BILLED DIAG	9	The diagnosis is inconsistent with the patient's age.	M64	Missing/incomplete/invalid other diagnosis.	CO
2515	THE COB PAYMENT IS LESS THAN WHAT IS EXPECTED FROM THE INSURANCE CARR	133	The disposition of this claim/service is pending further review.	MA92	Missing plan information for other insurance. (Modified 2/1/04) Related to N245	PI
2516	PROVIDER TYPE NOT ON TPL MATRIX	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N59	Please refer to your provider manual for additional program and provider information.	CO
2517	TPL ON MEMBER FILE, NOT ON CLAIM (PAY CLAIM)	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO
2518	PROVIDER TYPE - CLAIM INPUT CONFLICT	170	Payment is denied when performed/billed by this type of provider.	N95	This provider type/provider specialty may not bill this service.	CO
2519	OTHER INSURANCE COVERAGE WAS DENIED DUE TO POLICY LIMITS OR POLICY DAT	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N4	Missing/incomplete/invalid prior insurance carrier EOB.	CO
2520	OTHER INSURANCE FOUND A SUBMISSION ERROR ��? REQUIRES MANUAL REVIEW FOR	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N4	Missing/incomplete/invalid prior insurance carrier EOB.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2521	MEMBER HAS COB RESOURCE ON FILE AND THE SERVICE OR COB RESOURCE INDICA	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO
2522	MEMBER IS NOT ELIGIBLE FOR THESE SERVICES	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
2524	OVERNITE LABOR ROOM REQUIRES OCC CODE 51 AND DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M45	Missing/incomplete/invalid occurrence code(s). (Modified 12/2/04) Related to N299	CO
2526	PCS PRIOR AUTHORIZATION NOT ON FILE	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
2527	PCS - NO UNITS AUTHORIZED FOR THESE DATES OF SERVICES	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
2528	PCS PRIOR AUTHORIZATION UNITS USED	198	Payment Adjusted for exceeding precertification/ authorization.	M62	Missing/incomplete/invalid treatment authorization code.	CO
2535	VOID DUE TO TRANSFER OF RESOURCES PENALTY INDICATED	100	Payment made to patient/insured/responsible party.	N59	Please refer to your provider manual for additional program and provider information.	OA
2536	6TH DIAGNOSIS - AGE CONFLICT FOR BILLED DIAG	9	The diagnosis is inconsistent with the patient's age.	M64	Missing/incomplete/invalid other diagnosis.	CO
2537	7TH DIAGNOSIS - AGE CONFLICT FOR BILLED DIAG	9	The diagnosis is inconsistent with the patient's age.	M64	Missing/incomplete/invalid other diagnosis.	CO
2538	CMO CO-PAY/MEMBER HAS TPL	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2539	9TH DIAGNOSIS - AGE CONFLICT FOR BILLED DIAG	9	The diagnosis is inconsistent with the patient's age.	M64	Missing/incomplete/invalid other diagnosis.	CO
2540	ADMIT DIAGNOSIS - AGE CONFLICT FOR BILLED DIAG	9	The diagnosis is inconsistent with the patient's age.	MA65	Missing/incomplete/invalid admitting diagnosis.	CO
2541	ENCOUNTER MEMBER ID NUMBER NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO
2542	ENCOUNTER MEMBER NOT ELIGIBLE FOR HEADER DOS	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
2543	ENCOUNTER MEMBER INELIGIBLE ON DETAIL DOS	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
2544	ENCOUNTER FROM DATE OF SERVICE IS INVALID - DETAIL	242	Services not provided by network/primary care providers.	M52	Missing/incomplete/invalid 'from' date(s) of service.	CO
2545	ENCOUNTER FDOS IS AFTER THROUGH DOS - HEADER	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M52	Missing/incomplete/invalid 'from' date(s) of service.	CO
2546	ENCOUNTER PROVIDER NUMBER IS MISSING OR INVALID	242	Services not provided by network/primary care providers.	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO
2547	CMO CO-PAY/MEMBER HAS MEDICARE	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2548	ENCOUNTER EPSDT - FAMILY PLANNING INDICATOR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N78	The necessary components of the child and teen checkup (EPSDT) were not completed.	CO
2549	ADJUSTMENT SUSPEND FOR MANUAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
2550	SERVICE NOT REFERRED BY PRIMARY CARE CASE MANAGER	38	Services not provided or authorized by designated (network/primary care) providers.	N55	Procedures for billing with group/referring/performing providers were not followed.	CO
2551	ENCOUNTER TOOTH SURFACE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N75	Missing/incomplete/invalid tooth surface information.	CO
2552	PROVIDER NOT ELIGIBLE TO PROVIDE SERVICE/MEDICAID	185	The rendering provider is not eligible to perform the service billed.	N95	This provider type/provider specialty may not bill this service.	CO
2553	ENCOUNTER REFILL INDICATOR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N75	Missing/incomplete/invalid tooth surface information.	CO
2554	ENCOUNTER TYPE OF BILL MISSING OR INVALID	242	Services not provided by network/primary care providers.	MA30	Missing/incomplete/invalid type of bill.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2555	ENCOUNTER ADMIT DATE MISSING OR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA40	Missing/incomplete/invalid admission date.	CO
2556	MEMBER IS NOT WAIVER ELIGIBLE	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
2557	ENCOUNTER 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. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA43	Missing/incomplete/invalid patient status.	CO
2558	ENCOUNTER OCCURRENCE CODE INVALID	242	Services not provided by network/primary care providers.	M45	Missing/incomplete/invalid occurrence code(s). (Modified 12/2/04) Related to N299	CO
2559	EVALUATION AND MANAGEMENT VISITS NOT COVERED SAME DAY AS PSYCHIATRIC	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
2560	MEMBER SERVICES COVERED BY CMO PLAN	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	N30	Patient ineligible for this service.	OA
2561	MULTIPLE AUTOMATED TESTS CANNOT BE BILLED ON SAME DOS	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
2562	SERVICE NOT ALLOWED DURING PRTF STAY - ALLOWED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
2563	MEMBER NOT ENROLLED IN CMO FOR DOS	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M52	Missing/incomplete/invalid 'from' date(s) of service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2564	COMPLETE SCREENING NON-COV SAME DOS AS VISION/HEARING	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
2565	INTERPERIODIC VISION/HEARING NON-COV SAME DOS AS COMPLETE SCREENING	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
2566	RENDERING PROVIDER CAN ONLY SUBMIT CROSSOVER CLAIMS	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95	This provider type/provider specialty may not bill this service.	CO
2567	PAYMENT REDUCED - HOSPITAL LEAVE EXCEEDS 7 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
2568	NEWBORN SCREENING LIMIT EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
2569	SEVENTH SURGICAL PROCEDURE INVALID FOR MEMBER SEX	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
2570	SEVENTH SURG PROC AGE CONFLICT FOR BILLED ICD	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
2571	DOS UNDER ADMINISTRATIVE REVIEW FOR MEMBER - DTL	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
2572	MAXIMUM REIMBURSEMENT FOR THIS EQUIPMENT IS 10 MONTHS RENTAL	119	Benefit maximum for this time period or occurrence has been reached.	N370	Billing exceeds the rental months covered/approved by the payer.	CO
2573	ENCOUNTER ADMIT DIAGNOSIS IS MISSING OR INVALID	167	This (these) diagnosis(es) is (are) not covered.	MA65	Missing/incomplete/invalid admitting diagnosis.	CO
2574	SIXTH DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS	9	The diagnosis is inconsistent with the patient's age.	N59	Please refer to your provider manual for additional program and provider information.	CO
2575	SEVENTH DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS	9	The diagnosis is inconsistent with the patient's age.	M64	Missing/incomplete/invalid other diagnosis.	CO
2576	EIGHTH DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS	9	The diagnosis is inconsistent with the patient's age.	M64	Missing/incomplete/invalid other diagnosis.	CO
2577	NINTH DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS	9	The diagnosis is inconsistent with the patient's age.	M64	Missing/incomplete/invalid other diagnosis.	CO
2578	ADMIT DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS	9	The diagnosis is inconsistent with the patient's age.	MA65	Missing/incomplete/invalid admitting diagnosis.	CO
2579	ENCOUNTER EMERGENCY DIAGNOSIS CODE IS INVALID	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
2580	ENCOUNTER SECOND DIAGNOSIS IS INVALID	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2581	MEMBER IS LOCKED-IN TO ANOTHER PHYSICIAN	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N59	Please refer to your provider manual for additional program and provider information.	CO
2582	ENCOUNTER THIRD DIAGNOSIS IS INVALID	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
2583	ENCOUNTER FOURTH DIAGNOSIS IS INVALID	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
2584	ENCOUNTER FIFTH DIAGNOSIS IS INVALID	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
2585	ENCOUNTER SIXTH DIAGNOSIS IS INVALID	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
2586	ENCOUNTER SEVENTH DIAGNOSIS IS INVALID	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
2587	ADJUSTMENT REQUEST IS FOR A PHARMACY, ENCOUNTER OR CONVERTED CLAIM	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N59	Please refer to your provider manual for additional program and provider information.	CO
2588	CATEGORY OF SERVICE FOR ORIGINAL PAID CLAIM DOES NOT MATCH	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N180	This item or service does not meet the criteria for the category under which it was billed.	CO
2589	ICWP PROCEDURE NOT ALLOWED SAME CLAIM AS TBI PROC. REBILL ON SEPARATE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.	CO
2590	MEDICAL PROFESSIONAL-EXACT DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2591	HOME HEALTH-EXACT DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2592	MEDICAL PROFESSIONAL-POSSIBLE DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2593	HOME HEALTH-POSSIBLE DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2594	HOME HEALTH VISITS EXCEED 75 PER CALENDAR YEAR LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
2595	HOME HEALTH VISITS EXCEED 50 PER CALENDAR YEAR LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
2596	REVENUE CODE 169 CONFLICTS WITH ANOTHER ACCOMMODATION REVENUE CODE ON	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M50	Missing/incomplete/invalid revenue code(s).	CO
2597	BIRTHING CENTER IS NON-COVERED WHEN BILLED WITH LABOR / DELIVERY	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M50	Missing/incomplete/invalid revenue code(s).	CO
2598	MULTIPLE LINES OF REVENUE CODE 190 OR 192 BILLED ON NH CLAIM	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO
2599	PSYCHIATRIC SERVICE NOT REIMBURSABLE. HOSPITAL ADMIT/VISIT HAS BEEN	119	Benefit maximum for this time period or occurrence has been reached.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2600	PSYCHIATRIC SERVICE NOT COVERED ON THE SAME DAY AS HOSPITAL ADMIT/VIS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N20	Service not payable with other service rendered on the same date.	CO
2601	PART A CROSSOVER SPANS 20020501	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N63	Rebill services on separate claim lines.	CO
2602	MULTIPLE DRUG SCREEN PROCEDURE CODES ARE LIMITED TO 25 PER FISCAL YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
2603	PROV ID ON CLAIM DOES NOT MATCH PROV ID ON PA	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
2604	SERVICE AND/OR DATES DO NOT MATCH PRIOR AUTH	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO
2606	PRIOR AUTH UNITS/AMOUNTS USED	198	Payment Adjusted for exceeding precertification/ authorization.	N45	Payment based on authorized amount.	CO
2607	OBSERVATION HOURS MISSING, INVALID OR EXCEED MAXIMUM ALLOWABLE UNITS	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	M26	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refun	CO
2608	ENCOUNTER EIGHTH DIAGNOSIS IS INVALID	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2609	ENCOUNTER POS IS MISSING OR INVALID	58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	M77	Missing/incomplete/invalid place of service.	CO
2610	ENCOUNTER POS = 21 HOSP ADMIT DATE MISSING/INVALID	242	Services not provided by network/primary care providers.	MA40	Missing/incomplete/invalid admission date.	CO
2611	PROVIDER IS NOT ALLOWED TO BILL PROCEDURE 6 MONTHS AFTER ENROLLMENT	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N55	Procedures for billing with group/referring/performing providers were not followed.	CO
2612	TOOTH NUM ON CLAIM DOES NOT MATCH TOOTH NUM ON PA	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
2613	HEADER OR DETAIL SERVICE DATE IS AFTER THE BILLING DATE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO
2614	DIAG CODE MISSING/NOT ON FILE-INPATIENT CLAIMS	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
2615	NO PROVIDER RATE FOR DATE OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
2616	PROCEDURE NOT COMPENSABLE FOR ASSISTANT SURGEON	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	N95	This provider type/provider specialty may not bill this service.	CO
2617	ENCOUNTER POS IS MISSING OR INVALID - DETAIL	58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	M77	Missing/incomplete/invalid place of service.	CO
2618	ENCOUNTER SURGICAL PROCEDURE CODE INVALID	242	Services not provided by network/primary care providers.	M67	Missing/incomplete/invalid other procedure code(s). (Modified 12/2/04) Related to N302	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2619	ENCOUNTER PROVIDER NAME MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N256	Missing/incomplete/invalid billing provider/supplier name.	CO
2621	DOS UNDER ADMINISTRATIVE REVIEW FOR MEMBER - HDR	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
2622	RENDERING PROVIDER ON CLAIM DOESNT MATCH SOURCE PROVIDER ON LOCK-IN	133	The disposition of this claim/service is pending further review.	N290	Missing/incomplete/invalid rendering provider primary identifier.	PI
2623	THE CLAIM WAS CREATED BY A MASS ADJUSTMENT OR A MASS CREDIT	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA67	Correction to a prior claim.	CO
2624	EIGHTH SURGICAL PROCEDURE INVALID FOR MEMBER SEX	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
2625	NINTH SURGICAL PROCEDURE INVALID FOR MEMBER SEX	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
2627	EIGHTH SURG PROC AGE CONFLICT FOR BILLED ICD	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
2628	NINTH SURG PROC AGE CONFLICT FOR BILLED ICD	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
2629	SEVENTH DIAG - AGE CONFLICT FOR COVERED DIAG	6	The procedure/revenue code is inconsistent with the patient's age.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
2630	EIGHTH DIAG - AGE CONFLICT FOR COVERED DIAG	6	The procedure/revenue code is inconsistent with the patient's age.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
2631	THIS IS A CROSSOVER CLAIM AND ACCORDING TO THE DATABASE THE MEMBER IS	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2632	PREGNANCY INDICATOR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
2633	RESUBMIT WITH DPH/HIS(3)-57 FORM FROM CHILDRENS MEDICAL SERVICE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N512	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time without change to the adjudication.	CO
2634	NINTH DIAG - AGE CONFLICT FOR COVERED DIAG	6	The procedure/revenue code is inconsistent with the patient's age.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
2635	DATE PRESCRIBED IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N57	Missing/incomplete/invalid prescribing date. (Modified 12/2/04) Related to N304	CO
2636	THIRD PARTY PAYMENT AMOUNT INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2637	ACCIDENT RELATED CAUSE IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
2638	ADJUSTMENT OF OUTLIER CLAIMS IS NOT ALLOWED VIA THE WEB PORTAL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO
2639	HOSPICE FACILITY ID IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N270	Missing/incomplete/invalid other provider primary identifier.	CO
2640	MEDICARE BLOOD DEDUCTIBLE AMOUNT INVALID	66	Blood Deductible.	M79	Missing/incomplete/invalid charge.	PR
2641	CMO SUBCOPAY IS NON-NUMERIC	2	Coinsurance Amount	M79	Missing/incomplete/invalid charge.	PR
2642	INVALID PROVIDER NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO
2643	ABORTION REQUIRES REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2644	PROCEDURE CODE MODIFIER NOT PAYABLE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N519	Invalid combination of HCPCS modifiers.	CO
2645	MEDICARE PSYCH ADJUSTMENT AMOUNT INVALID	122	Psychiatric reduction.	M79	Missing/incomplete/invalid charge.	CO
2646	PROVIDER RATE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
2647	HEADER BILLED DATE IS PRIOR TO DATES OF SERVICE	110	Billing date predates service date.	N59	Please refer to your provider manual for additional program and provider information.	CO
2648	DATE OVER 1 YR AND OVER 180 DAYS AFTER MEDICARE PAID DATE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N307	Missing/incomplete/invalid adjudication or payment date.	CO
2649	MISSING OR INVALID PAYER DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N307	Missing/incomplete/invalid adjudication or payment date.	CO
2650	PROVIDER TYPE SPECIALITY GROUP NOT FOUND	148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.	N270	Missing/incomplete/invalid other provider primary identifier.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2651	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. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
2652	MISSING/INVALID OTHER PAYER COVERAGE TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N245	Incomplete/invalid plan information for other insurance	CO
2653	BENEFIT PLAN GROUP NOT FOUND	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N30	Patient ineligible for this service.	CO
2654	CMO REFORM TRANSPLANT SERVICE	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	N30	Patient ineligible for this service.	OA
2655	PAYEE PROVIDER NOT FOUND	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N280	Missing/incomplete/invalid pay-to provider primary identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2656	PAYEE PROVIDER NOT ELIGIBLE FOR DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N282	Missing/incomplete/invalid pay-to provider secondary identifier.	CO
2657	HEALTH CHECK REFERRAL CODES PRESENT ON A NON HEALTH CHECK CLAIM	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO
2658	CLAIM SPANS ELIG SEGMENTS-QMB, PE, HOSPICE AID CAT	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30	Patient ineligible for this service.	CO
2659	POSSIBLE EMERGENCY	11	The diagnosis is inconsistent with the procedure.	N59	Please refer to your provider manual for additional program and provider information.	CO
2660	ZERO AMOUNT TO PAY	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N524	Based on policy this payment constitutes payment in full.	CO
2661	MEDICAL DIAGNOSIS IS REQUIRED FOR THIS CLAIM	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M64	Missing/incomplete/invalid other diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2664	PCS DAYS BILLED SPAN DIFFERENT MONTHS	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N61	Rebill services on separate claims.	CO
2665	A CONFLICT EXISTS BETWEEN THE AID CATEGORY (PEACHCARE 790 THRU 793) AN	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2697	QMB MEMBER - BILL MEDICARE FIRST	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N192	Patient is a Medicaid/Qualified Medicare Beneficiary.	CO
2698	PROCEDURE IS ICD-10 BEFORE ICD-10 LIVE DATE	181	Payment adjusted because this procedure code was invalid on the date of service	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
2699	PROCEDURE IS ICD-9 AFTER ICD-10 LIVE DATE	181	Payment adjusted because this procedure code was invalid on the date of service	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
2700	DIAGNOSIS IS ICD-10 BEFORE ICD-10 LIVE DATE	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
2701	DIAGNOSIS IS ICD-9 AFTER ICD-10 LIVE DATE	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
2702	DOS CAN NOT SPAN THE ICD-10 LIVE DATE.	95	Benefits adjusted. Plan procedures not followed.	N61	Rebill services on separate claims.	PR
2703	ENCOUNTER DIAGNOSIS IS ICD-10 BEFORE ICD-10 LIVE DATE	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
2704	ENCOUNTER DIAGNOSIS IS ICD-9 AFTER ICD-10 LIVE DATE	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
2705	ENCOUNTER HDR DOS CAN NOT SPAN THE ICD-10 LIVE DATE	95	Benefits adjusted. Plan procedures not followed.	N61	Rebill services on separate claims.	PR
2706	PRIMARY PROCEDURE QUALIFIER INVALID	181	Payment adjusted because this procedure code was invalid on the date of service	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
2707	SECONDARY PROCEDURE QUALIFIER INVALID	181	Payment adjusted because this procedure code was invalid on the date of service	M67	Missing/incomplete/invalid other procedure code(s). (Modified 12/2/04) Related to N302	CO
2708	PRIMARY DIAGNOSIS QUALIFIER INVALID	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2709	SECONDARY DIAGNOSIS QUALIFIER INVALID	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.	CO
2710	ADMITTING DIAGNOSIS QUALIFIER INVALID	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	M65	One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each interpreting physician.	CO
2711	PATIENT REASON DIAGNOSIS QUALIFIER INVALID	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.	CO
2712	EXTERNAL CAUSE OF INJURY DIAGNOSIS QUALIFIER INVALID	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.	CO
2713	ENCOUNTER PROCEDURE IS ICD-10 BEFORE ICD-10 LIVE DATE	181	Payment adjusted because this procedure code was invalid on the date of service	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
2714	ENCOUNTER PROCEDURE IS ICD-9 AFTER ICD-10 LIVE DATE	181	Payment adjusted because this procedure code was invalid on the date of service	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
2715	STERILIZATION CONSENT FORM IS INCOMPLETE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N228	Incomplete/invalid consent form.	CO
2716	HYSTERECTOMY CONSENT FORM REQUIRED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N28	Consent form requirements not fulfilled.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2717	STERILIZATION CONSENT FORM NOT SIGNED BY PHYSICIAN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N228	Incomplete/invalid consent form.	CO
2718	INVALID SURGICAL PROCEDURE CODE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
2719	REFILE CLAIM WITH OPERATIVE REPORT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M29	Missing operative report. (Modified 2/28/03) Related to N233	CO
2720	INCORRECT MEMBER DATE OF BIRTH ON CONSENT FORM	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N228	Incomplete/invalid consent form.	CO
2721	FURTHER DESCRIPTION OF SERVICE REQUIRED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N29	Missing documentation/orders/notes/summary/report/chart. (Modified 2/28/03, 8/1/05) Related to N225	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2722	STRENGTH AND DOSAGE OF INJECTION MEDICATION REQ	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	CO
2723	SERVICES REQ DOCUMENTATION FOR MEDICAL NECESSITY	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	N29	Missing documentation/orders/notes/summary/report/chart. (Modified 2/28/03, 8/1/05) Related to N225	CO
2724	REFILE CLAIM WITH CONSULTATION/PROGRESS NOTES	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N29	Missing documentation/orders/notes/summary/report/chart. (Modified 2/28/03, 8/1/05) Related to N225	CO
2725	SERVICE NOT COVERED AS BILLED	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N431	Service is not covered with this procedure.	CO
2726	REFERRING PHYSICIAN REQUIRED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N286	Missing/incomplete/invalid referring provider primary identifier.	CO
2727	ANOTHER PROVIDER HAS BEEN PAID FOR THESE SERVICES	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2728	SERVICES ARE NOT AUTHORIZED	204	This service/equipment/drug is not covered under the patient's current benefit plan	N59	Please refer to your provider manual for additional program and provider information.	CO
2729	DENIED AFTER SPECIAL REVIEW	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N35	Program integrity/utilization review decision.	CO
2730	HYSTERECTOMY CONSENT FORM SIGNED AFTER SURGERY	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N28	Consent form requirements not fulfilled.	CO
2733	SERVICES/SUPPLY NOT IN SCOPE OF PROGRAM	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N431	Service is not covered with this procedure.	CO
2734	PROCEDURE/REVENUE CODE-REQUIRE PRIOR AUTHORIZATION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M62	Missing/incomplete/invalid treatment authorization code.	CO
2735	MEMBER INELIGIBLE ON SERVICE DATES	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
2736	MODIFIER ADDED/DELETED DUE TO MEDICAL REVIEW	182	Payment adjusted because the procedure modifier was invalid on the date of service	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	CO
2737	INVALID MODIFIER FOR THIS PROCEDURE	182	Payment adjusted because the procedure modifier was invalid on the date of service	N519	Invalid combination of HCPCS modifiers.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2738	INVALID PROCEDURE CODE USE VALID CPT OR HCPC CODE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
2739	ONE AMBULATORY SURGERY ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2740	INVALID CODE FOR NARRATIVE DESCRIPTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
2741	INVALID SUBMITTED CHARGE	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	M54	Missing/incomplete/invalid total charges.	CO
2742	AUTHORIZED PHYSICAL REQUIRES ABCDM-16	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N29	Missing documentation/orders/notes/summary/report/chart. (Modified 2/28/03, 8/1/05) Related to N225	CO
2743	EXCEPTION CODE 743	147	Provider contracted/negotiated rate expired or not on file.	N59	Please refer to your provider manual for additional program and provider information.	CO
2744	AUTHORIZED PHYSICAL DOES NOT MATCH ABCDM-16	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2745	REQUESTED ADDITIONAL INFORMATION NOT RECEIVED	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	N59	Please refer to your provider manual for additional program and provider information.	CO
2746	DENTAL X-RAYS ARE REQUIRED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N40	Missing x-ray. (Modified 2/1/04) Related to N242	CO
2765	SUBMIT A VALID HYSTERECTOMY ACKNOWLEDGEMENT AS AN ATTACHMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N28	Consent form requirements not fulfilled.	CO
2789	ICD PROCEDURE/DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
2803	DENTAL-EXACT DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2804	DENTAL-POSSIBLE DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
2806	PRACTITIONER-EXACT DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2807	PRACTITIONER-POSSIBLE DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
2813	PROCEDURE REQUIRES MEDICAL REVIEW BY FISCAL AGENT	112	Payment adjusted as not furnished directly to the patient and/or not documented.	N35	Program integrity/utilization review decision.	CO
2824	OUTPATIENT-POSSIBLE DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
2826	HOME HEALTH-EXACT DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2828	HOME HEALTH-POSSIBLE CONFLICT OF ANOTHER CLAIM	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
2829	INPATIENT-EXACT DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2830	INPATIENT-POSSIBLE DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
2840	MULTIPLE SURGERY PROCEDURE BILLED SEPARATELY	234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	N390	This service cannot be billed separately.	CO
2841	SERVICE NOT ALLOWED WITH CRITICAL CARE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
2842	SERVICE NOT ALLOWED SAME DATE OF SERVICE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2843	EXACT DUPLICATE OF A PREVIOUSLY PAID SERVICE	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
2844	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID SERVICE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2845	OPTOMETRIST-EXACT DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2846	OPTOMETRIST-POSSIBLE DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
2847	SUSPECT DUPLICATE - CHILDRENS INTERVENTION SERVICES VERSUS OUTPATIENT	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2848	COS 900 BILLED FOR SAME DOS AS COS 010, COS 680, COS 681	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
2849	COS 900 BILLED FOR OVERLAPPING DOS AS COS 010, COS 680, COS 681	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2857	THE HOSPICE SUBMITTED UNITS OF SERVICE ARE GREATER THAN TOTAL DAYS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M53	Missing/incomplete/invalid days or units of service.	CO
2877	REVIEW EDITS 4005/4006/4009/4084 PRIOR TO CUTBACK PA CUTBACK PERFORMED	198	Payment Adjusted for exceeding precertification/ authorization.	N45	Payment based on authorized amount.	CO
2896	FILE SEPARATE CLAIMS FOR DIFFERENT YEARS	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N61	Rebill services on separate claims.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2914	HOSPICE REGION DOESNT MATCH MEMBER HOSPICE REGION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N79	Service billed is not compatible with patient location information.	CO
2915	ONLY ONE TOOTH EXTRACTION ALLOWED PER DOS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
2916	POST-OPERATIVE CARE BY NON-OPERATING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N90	Covered only when performed by the attending physician.	CO
2917	PRE-OPERATIVE CARE BY NON-OPERATING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N90	Covered only when performed by the attending physician.	CO
2918	CLAIM DOS ARE OUTSIDE DIALYSIS CERTIFICATION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
2919	MEMBER ID NUM NOT ON FILE	140	Patient/Insured health identification number and name do not match.	N382	Missing/incomplete/invalid patient identifier.	CO
2920	INVALID REFERRING PROVIDER OVERRIDE SPECIFIED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N286	Missing/incomplete/invalid referring provider primary identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2925	DIAGNOSIS NOT COVERED FOR DOS	147	Provider contracted/negotiated rate expired or not on file.	M64	Missing/incomplete/invalid other diagnosis.	CO
2959	CANNOT PROCESS NEGATIVE AMOUNTS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO
2960	PRACTITIONER-POSSIBLE CONFLICT WITH ANOTHER CLAIM	B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.	N59	Please refer to your provider manual for additional program and provider information.	CO
2976	HYSTERECTOMY REQUIRE SIGN DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N28	Consent form requirements not fulfilled.	CO
2977	REFILE CLAIM WITH MEDICAL RECORD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M127	Missing patient medical record for this service. (Modified 2/28/03) Related to N237	CO
2978	INPATIENT HOSPITAL CLAIM PAID THIS DATE OF SERVICE	60	Charges for outpatient services with this proximity to inpatient services are not covered.	N47	Claim conflicts with another inpatient stay.	CO
2979	NURSING HOME CLAIMS PAID THIS DATE OF SERVICE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
2980	PROCEDURE NOT PAYABLE FOR THIS AGE	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
2981	VERIFY PA FOR THIS PROCEDURE/DATE OF SERVICE	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO
2982	REFILE WITH PHYSICIAN PROGRESS NOTES	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N29	Missing documentation/orders/notes/summary/report/chart. (Modified 2/28/03, 8/1/05) Related to N225	CO
2983	PROV ID ON CLAIM DOES NOT MATCH PROV ID ON PA	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N54	Claim information is inconsistent with pre-certified/authorized services.	CO
2984	DIAGNOSIS NOT PAYABLE FOR NURSE MIDWIFE	12	The diagnosis is inconsistent with the provider type.	N95	This provider type/provider specialty may not bill this service.	CO
2985	PROVIDER IS SUSPENDED OR TERMINATED	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO
3000	PA UNITS PARTIALLY AVAILABLE	198	Payment Adjusted for exceeding precertification/ authorization.	N45	Payment based on authorized amount.	CO
3001	PRIOR AUTHORIZATION/PRECERT NOT ON FILE	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
3010	PRIOR AUTHORIZATION NUMBER IS MISSING	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
3011	DOS NOT WITHIN PA/PRECERT EFFECTIVE DATES	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3023	FIRST SURGERY CODE IS ELECTIVE AND HAS NO PRIOR AUTH NUMBER. NON-PRIOR	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N29	Missing documentation/orders/notes/summary/report/chart. (Modified 2/28/03, 8/1/05) Related to N225	CO
3024	CLAIM COS DOES NOT MATCH PA/PRECERT COS	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO
3025	PA UNIT RATE IS REQUIRED, NO SYSTEM PRICE ON FILE	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
3026	PRIOR AUTHORIZATION IS REQUIRED FOR PRICING	198	Payment Adjusted for exceeding precertification/ authorization.	N299	Missing/incomplete/invalid occurrence date(s).	CO
3027	PRIOR AUTHORIZATION DOLLARS ARE ZERO	198	Payment Adjusted for exceeding precertification/ authorization.	N299	Missing/incomplete/invalid occurrence date(s).	CO
3033	PRIOR AUTHORIZATION IS REQUIRED WHEN PURCHASE/REPAIR EXCEEDS MAX LIMIT	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N435	Exceeds number/frequency approved /allowed within time period without support documentation.	CO
3034	EMERGENCY TREATMENT UNDER REVIEW-DENTAL	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
3035	SERVICE DATE 120 DAYS AFTER PA ISSUED	198	Payment Adjusted for exceeding precertification/ authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO
3036	ELECTIVE SURGERY EMERGENCY INDICATED	40	Charges do not meet qualifications for emergent/urgent care.	N59	Please refer to your provider manual for additional program and provider information.	CO
3037	MEMBER ID IS INACTIVE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N382	Missing/incomplete/invalid patient identifier.	CO
3039	OUT OF STATE SERVICES NOT PRIOR AUTHORIZED AND NON EMERGENCY AND ARE T	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3041	PRIOR AUTH LINE NOT APPROVED	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO
3042	MEMBER ID DOES NOT MATCH PRIOR AUTHORIZATION	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO
3043	PRIOR AUTHORIZATION/PROCEDURE CODE MODIFIER CONFLICT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N519	Invalid combination of HCPCS modifiers.	CO
3044	PROVIDER NUMBER DOES NOT MATCH PRIOR AUTHORIZATION	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO
3045	TOOTH NUMBR/SURFACE/QUAD DOES NOT MATCH PA/PRECERT	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO
3046	REQUESTING PROV SPECIALTY DOES NOT MATCH REND PROV SPECIALTY	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO
3047	PRECERT/ PRIOR APPROVAL IS REQUIRED FOR SERVICE BILLED	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
3048	DIAGNOSIS/PRIOR AUTHORIZATION CONFLICT	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO
3049	MEDICAL INPATIENT PA NOT ON FILE	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3050	CLAIM PROCEDURE CODE DOES NOT MATCH PRIOR AUTHORIZATION PROCEDURE CODE	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO
3052	PRIOR AUTHORIZATION UNITS/AMOUNT HAVE BEEN EXHAUSTED	198	Payment Adjusted for exceeding precertification/ authorization.	N299	Missing/incomplete/invalid occurrence date(s).	CO
3053	DS WAIVER NOT APPROVED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M62	Missing/incomplete/invalid treatment authorization code.	CO
3054	UNIT RATE NOT ALLOWED	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO
3055	BILLED AMOUNT INVALID	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	M54	Missing/incomplete/invalid total charges.	CO
3056	THE DME SERIAL NUMBER IS REQUIRED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M99	Missing/incomplete/invalid Universal Product Number/Serial Number.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3057	AMBULANCE MILEAGE EXCEEDING 150 MILES PER 1-WAY TRIP REQUIRES PA	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N435	Exceeds number/frequency approved /allowed within time period without support documentation.	CO
3058	L1 PA CAN NOT BE USED IF L2 SAME DOS	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
3059	MENTAL HEALTH PRIOR APPROVAL NOT VALID	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
3065	PROCEDURE BILLED IS PRECERTIFIED FOR OUTPATIENT ONLY	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO
3066	PA ALLOWED AMOUNT EXCEEDS NON-PA ALLOWED AMOUNT	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M139	Denied services exceed the coverage limit for the demonstration.	CO
3067	MAXIMUM NUMBER OF MONTHLY PA UNITS HAS BEEN REACHED	198	Payment Adjusted for exceeding precertification/ authorization.	N45	Payment based on authorized amount.	CO
3068	MAXIMUM NUMBER OF DAILY PA UNITS HAS BEEN REACHED	198	Payment Adjusted for exceeding precertification/ authorization.	N45	Payment based on authorized amount.	CO
3069	CATEGORY OF SERVICE TO NURSING HOME OR SWINGBED PA TYPE MISMATCH	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO
3070	PA INCREMENTAL UNITS EXCEEDED OR HAVE BEEN USED	198	Payment Adjusted for exceeding precertification/ authorization.	N45	Payment based on authorized amount.	CO
3071	SERVICES ARE NOT PAYABLE UNDER A CMO PRIOR AUTHORIZATION. REQUEST A MM	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
3072	MULTIPLE PRIOR AUTHORIZATION NUMBERS FOUND FOR A MONTH FOR CCSP CLAIM	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3236	ENCOUNTER PROCEDURE CODE INVALID OR MISSING	242	Services not provided by network/primary care providers.	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
3312	ENCOUNTER PRESCRIPTION NUMBER IS MISSING	242	Services not provided by network/primary care providers.	N388	Missing/incomplete/invalid prescription number	CO
3314	ENCOUNTER ADMIT TYPE CONTAINS AN INVALID VALUE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA41	Missing/incomplete/invalid admission type.	CO
3317	ENCOUNTER SURGICAL PROCEDURE DATE MISSING/INVALID	242	Services not provided by network/primary care providers.	N341	Missing/incomplete/invalid surgery date.	CO
3322	UNITS OF SERVICE IS INVALID ON A HOSPICE CLAIM	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M53	Missing/incomplete/invalid days or units of service.	CO
3340	PROCEDURE CODE REQUIRES MANUAL PRICING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3342	ENCOUNTER FMR ICN NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
3348	DIAGNOSIS CODE NOT COVERED FOR BIRTH CENTER PROCEDURE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
3358	CLAIM REQUIRES DCH MANUAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
3359	MODIFIER REQUIRES REVIEW PRIOR TO PAYMENT	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
3360	TAXONOMY IS MISSING OR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N255	Missing/incomplete/invalid billing provider taxonomy.	CO
3371	MULTIPLE RATE RECORDS FOUND FOR HOSPICE PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3373	NO COPAY FOR BILLED PROCEDURE	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N524	Based on policy this payment constitutes payment in full.	CO
3374	NO COPAY FOR BILLED DIAGNOSIS	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N524	Based on policy this payment constitutes payment in full.	CO
3375	NO COPAY FOR BILLED NDC	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N524	Based on policy this payment constitutes payment in full.	CO
3376	NO COPAY FOR BILLED REV CODE	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N524	Based on policy this payment constitutes payment in full.	CO
3377	NO COPAY FOR BILLED DRG	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N524	Based on policy this payment constitutes payment in full.	CO
3378	NO COPAY FOR BILLED ICD	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N524	Based on policy this payment constitutes payment in full.	CO
3379	NO/PARTIAL RATE SEGMENT FOR PROCEDURE/NDC COMBO	147	Provider contracted/negotiated rate expired or not on file.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3380	CHARGE DISALLOWED BY MEDICARE - REFER TO REOMB	204	This service/equipment/drug is not covered under the patient's current benefit plan	N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO
3393	ELEVEN (11) OR MORE UNITS MUST BE BILLED FOR PROCEDURE	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
3394	TOTAL CHARGES EXCEED THRESHOLD AMOUNT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO
3395	CALCULATED HEADER ALLOWED CHARGE TOO LARGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO
3397	COVERED DAYS INVALID FOR PER DIEM RATE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	MA32	Missing/incomplete/invalid number of covered days during the billing period.	CO
3399	AMBULANCE SERVICE A0425 BILLED WITH UNITS GREATER OR LESS THAN 10	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3400	ANESTHESIA BURN CODE UNIT CUTBACK	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
3402	SUBMIT A VALID STERILIZATION CONSENT FORM AS AN ATTACHMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N3	Missing consent form. (Modified 2/28/03) Related to N228	CO
3403	MANUAL REVIEW CLAIMS THAT HAVE RECYCLED AND MET REJECTION CRITERIA	133	The disposition of this claim/service is pending further review.	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	PI
3404	RESUBMIT WITH MEDICAL JUST FOR INPATIENT ADMISSION, WITH/WITHOUT ATTAC	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N237	Incomplete/invalid patient medical record for this service.	OA
3405	COSMETIC PROCEDURES ARE NON-COVERED BECAUSE THEY ARE NOT DEEMED A MED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N383	Services deemed cosmetic are not covered	CO
3406	PROCEDURE BILLED NOT COVERED BY MEDICAID - IT IS AVAILABLE FROM STATE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N431	Service is not covered with this procedure.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3407	DIAGNOSIS NOT COVERED FOR OPTOMETRIC SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
3408	COVERAGE LIMITED TO DIABETES AND/OR PERIPHERIAL VASCULAR DISEASE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N216	Patient is not enrolled in this portion of our benefit package	CO
3409	REVENUE CODE 190 OR 192 IS REQUIRED ON CLAIM	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M50	Missing/incomplete/invalid revenue code(s).	CO
3410	INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE	150	Payment adjusted because the payer deems the information submitted does not support this level of service.	M25	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level	CO
3411	DIAGNOSIS TO PROCEDURE COMPARISON - PLEASE REFER TO YOUR PROVIDER MANU	11	The diagnosis is inconsistent with the procedure.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
3412	MAINTENANCE DIALYSIS MUST BE BILLED UNDER THE DIALYSIS PROGRAM	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N372	Only reasonable and necessary maintenance/service charges are covered.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3413	UNLISTED PROCEDURE - PLEASE REFER TO YOUR PROVIDER MANUAL FOR ADDITION	189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service	N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or an Unlisted procedure.	CO
3414	DIAGNOSIS CODE IS INVALID FOR DIALYSIS PROGRAM	11	The diagnosis is inconsistent with the procedure.	M64	Missing/incomplete/invalid other diagnosis.	CO
3415	NET TIME REQUIRED - SCHEDULED APPOINTMENT TIME	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N443	Missing/incomplete/invalid total time or begin/end time.	CO
3416	NET TIME REQUIRED - ACTUAL DROP-OFF TIME	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N443	Missing/incomplete/invalid total time or begin/end time.	CO
3417	NET TIME REQUIRED - SCHEDULED PICK-UP TIME	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N443	Missing/incomplete/invalid total time or begin/end time.	CO
3418	NET TIME REQUIRED - ACTUAL PICK-UP TIME	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N443	Missing/incomplete/invalid total time or begin/end time.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3419	ENCOUNTER DRG IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N208	Missing/incomplete/invalid DRG code	CO
3420	BILLED APT PROCEDURE NOT ALLOWED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N431	Service is not covered with this procedure.	CO
3421	ENCOUNTER DUPLICATE OTHER PAYER ID SUBMITTED	242	Services not provided by network/primary care providers.	N59	Please refer to your provider manual for additional program and provider information.	CO
3422	ENCOUNTER DRG IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N208	Missing/incomplete/invalid DRG code	CO
3423	DIAGNOSIS CODE IS INVALID FOR CATEGORY OF SERVICE	11	The diagnosis is inconsistent with the procedure.	M64	Missing/incomplete/invalid other diagnosis.	CO
3424	CLAIM DENIAL WAS SYSTEMATICALLY RESUBMITTED AND PAID WITH AN INTERIM R	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
3425	PROVIDER MUST BILL PROFESSIONAL COMPONENT FOR RADIOLOGY / PATHOLOGY	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N200	The professional component must be billed separately.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3426	BILL LAB ONLY FOR LABORATORY CHARGES	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M126	Missing/incomplete/invalid individual lab codes included in the test.	CO
3427	A LABORATORY HCPCS CODE MUST BE BILLED ON AN OUTPATIENT CLAIM WITH LAB	199	Revenue code and Procedure code do not match.	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
3428	COS, MODIFIER AND PROVIDER SPECIALTY ARE NOT VALID FOR ANESTHESIA	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	N95	This provider type/provider specialty may not bill this service.	CO
3429	MEDICARE ADJUSTMENT OR VOID CLAIMS CAN NOT CROSSOVER - BILL THEM DIRE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
3430	TWO EOBS RECEIVED ON THE 837 FOR THE SAME CARRIER. PLEASE SUBMIT A PAP	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N517	Resubmit a new claim with the requested information.	CO
3431	BENEFIT PLAN COVERAGE RULE NOT FOUND FOR 7TH DIAGNOSIS	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.	CO
3438	MEDICARE ALLOWED OR PAID AMOUNT IS ZERO OR MISSING	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N524	Based on policy this payment constitutes payment in full.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3440	FLU VACCINES NOT ALLOWED	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
3441	CLAIM MUST BE SPLIT-BILLED FOR CORRECT ELIGIBILITY DATES FOR QMB, PRES	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N192	Patient is a Medicaid/Qualified Medicare Beneficiary.	CO
3442	CLAIM PAYMENT ADJUSTED TO INTERIM RATE. CORRECT RATE PROCESSING WILL B	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
3443	A VALID ENCOUNTER CODE MUST BE USED WHEN BILLING RURAL HEALTH OR COMMU	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M67	Missing/incomplete/invalid other procedure code(s). (Modified 12/2/04) Related to N302	CO
3444	J2794 DENIED BECAUSE ORAL RISPERDAL DRUG WAS NOT PREVIOUSLY PAID	B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N59	Please refer to your provider manual for additional program and provider information.	OA
3445	PROCEDURE DENIED BECAUSE A PRIMARY CODE WAS NOT PREVIOUSLY PAID	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	N390	This service cannot be billed separately.	CO
3446	PROCEDURE DENIED BECAUSE A PREGNANCY WAS NOT FOUND IN HISTORY	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	N390	This service cannot be billed separately.	CO
3447	INTERIM PAYMENT CLAIM WAS REPROCESSED WITH THE CORRECTIONS MADE TO MMI	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
3448	A PAID ER VISIT IS REQUIRED ON CLAIM	B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N59	Please refer to your provider manual for additional program and provider information.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3450	VACCINE/ADMIN CODES ON SAME CLAIM MUST BE SAME DOS	B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N122	Add-on code cannot be billed by itself.	OA
3451	ADMIN CODE REQUIRES VACCINE CODE	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	N390	This service cannot be billed separately.	CO
3452	VACCINE CODE REQUIRES ADMIN CODE	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	N390	This service cannot be billed separately.	CO
3453	VACCINE CODE NOT ALLOWED FOR ADMIN CODE	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	N390	This service cannot be billed separately.	CO
3454	VACCINE BILLED UNITS MUST EQUAL ADMIN BILLED UNITS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
3455	MEMBER IS NOT ELIGIBLE FOR ADD-ON ALL DATES	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
3456	PROVIDER IS NOT AUTHORIZED FOR ADD-ON ALL DATES	B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N59	Please refer to your provider manual for additional program and provider information.	OA
3457	PROVIDER NOT AUTHORIZED TO RECEIVE ADD-ON PAYMENT	B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N59	Please refer to your provider manual for additional program and provider information.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3458	GMCF NCCI RECOMMENDED PAIR FOR REVIEW	133	The disposition of this claim/service is pending further review.	N59	Please refer to your provider manual for additional program and provider information.	PI
3459	GMCF NCCI RECOMMENDED PAIR FOR LATER REVIEW	133	The disposition of this claim/service is pending further review.	N59	Please refer to your provider manual for additional program and provider information.	PI
3460	NCCI AUDIT WAS BYPASSED DUE TO NCCI MODIFIER	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N19	Procedure code incidental to primary procedure.	OA
3461	PROCEDURES WITH A 50 MODIFIER ARE LIMITED TO ONE UNIT PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
3601	PROCEDURE/DIAGNOSIS/DRUG NOT COVERED FOR FAMILY PLANNING	181	Payment adjusted because this procedure code was invalid on the date of service	N431	Service is not covered with this procedure.	CO
3607	INPATIENT CLAIM BILLED FOR DIALYSIS PATIENT	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
3608	CO-INSURANCE INVALID FOR CATEGORY OF SERVICE BILLED	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N95	This provider type/provider specialty may not bill this service.	CO
3675	PRE-OP CARE BY NON-OPERATING PROVIDER-P/R	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N90	Covered only when performed by the attending physician.	CO
3699	PROVIDER NOT ENROLLED FOR ELECTRONIC BILLING	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N407	You are not an approved submitter for this transmission format.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3708	CLAIM DATES OF SERVICE ARE OUTSIDE DIALYSIS CERTIFICATION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N351	Service date outside of the approved treatment plan service dates.	CO
3709	ENCOUNTER TCN IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
3710	DUPLICATE ENCOUNTER TCN SUBMITTED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
3711	ENCOUNTER CLAIM STATUS PRESENT	242	Services not provided by network/primary care providers.	N59	Please refer to your provider manual for additional program and provider information.	CO
3712	ENCOUNTER PAID AMOUNT >= 0	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
3713	ENCOUNTER PAID DATE	242	Services not provided by network/primary care providers.	N307	Missing/incomplete/invalid adjudication or payment date.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3714	ENCOUNTER LINE PAID AMOUNT = 0	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
3715	ENCOUNTER LINE QUANTITY = 0 AND PAID AMOUNT > 0	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
3716	ENCOUNTER MEMBER NOT ENROLLED WITH NET BROKER FOR DOS	177	Payment denied because the patient has not met the required eligibility requirements	N59	Please refer to your provider manual for additional program and provider information.	CO
3717	MEMBER NOT ENROLLED WITH SUBMITTING CMO FOR DOS	177	Payment denied because the patient has not met the required eligibility requirements	N59	Please refer to your provider manual for additional program and provider information.	CO
3718	CMO RECEIPT DATE NOT VALID	242	Services not provided by network/primary care providers.	N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	CO
3719	MEDICARE CROSSOVER CLAIMS CAN NOT BE SUBMITTED AS ENCOUNTERS	242	Services not provided by network/primary care providers.	N59	Please refer to your provider manual for additional program and provider information.	CO
3720	EVERY ENCOUNTER CLAIM MUST CONTAIN AT LEAST ONE DETAIL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3721	ENCOUNTER NET BILLED AMOUNT NOT ZERO	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
3722	ENCOUNTER NET PAID AMOUNT NOT ZERO	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
3723	ENCOUNTER TRIP NUMBER IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
3724	ENCOUNTER INVALID NET PROCEDURE CODE	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
3725	ENCOUNTER INVALID NET MODIFIER CODE SUBMITTED	182	Payment adjusted because the procedure modifier was invalid on the date of service	N519	Invalid combination of HCPCS modifiers.	CO
3753	HEALTH CHECK REFERRAL CODES ARE INVALID OR MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N78	The necessary components of the child and teen checkup (EPSDT) were not completed.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
3755	ENCOUNTER CLAIM - STATUS AND PAYMENT DETERMINED BY THE CMO OR NET VENDOR	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	N59	Please refer to your provider manual for additional program and provider information.	OA
3842	VALUE CODE VISITS DONT CORRESPOND TO THE REVENUE CODE UNITS BILLED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M49	Missing/incomplete/invalid value code(s) or amount(s).	CO
3999	NONCOVERED PROCEDURE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
4000	MORE THAN TWO SURGICAL UNITS ON THE CLAIM	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N362	The number of Days or Units of Service exceeds our acceptable maximum.	OA
4001	BILLING PT/PS RESTRICTION FOR COVERED DIAGNOSIS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4002	INVALID REVENUE CODE FOR INJECTABLE DRUG	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M50	Missing/incomplete/invalid revenue code(s).	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4003	NO RATE ON FILE	147	Provider contracted/negotiated rate expired or not on file.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
4012	ABORTION CERTIFICATION OF NECESSITY MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
4014	NO/PARTIAL PRICING SEGMENT ON FILE FOR DETAIL DOS	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
4016	PROV TYPE DIAGNOSIS CONFLICT	12	The diagnosis is inconsistent with the provider type.	N95	This provider type/provider specialty may not bill this service.	CO
4018	PERF PT/PS RESTRICTION FOR COVERED DRG	185	The rendering provider is not eligible to perform the service billed.	N95	This provider type/provider specialty may not bill this service.	CO
4021	MEMBER PLAN RESTRICTION FOR BILLED PROCEDURE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N30	Patient ineligible for this service.	CO
4023	GENDER RESTRICTION FOR COVERED NDC	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
4026	MAX UNIT RESTRICTION FOR COVERED NDC	222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4029	POS RESTRICTION FOR COVERED DIAGNOSIS	58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	N428	Service/procedure not covered when performed in this place of service.	CO
4030	DIAG CODE INCOMPATIBLE FOR MEMBERS AGE - ENSURE MOTHERS DIAG IS NOT US	9	The diagnosis is inconsistent with the patient's age.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
4033	DETAIL DOES NOT MATCH THE CONFIGURED REIMBURSEMENT RULE PPS CANDIDATE	147	Provider contracted/negotiated rate expired or not on file.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
4034	PROCEDURE CODE/AGE CONFLICT	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
4035	PROCEDURE CODE IS INVALID FOR MEMBERS SEX	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
4036	PROCEDURE/PLACE OF SERVICE CONFLICT	5	The procedure code/bill type is inconsistent with the place of service.	N428	Service/procedure not covered when performed in this place of service.	CO
4037	DIAGNOSIS IS INCORRECT FOR PROCEDURE CODE BILLED	11	The diagnosis is inconsistent with the procedure.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4039	DIAGNOSIS CANNOT BE USED AS THE PRINCIPAL DIAGNOSIS	147	Provider contracted/negotiated rate expired or not on file.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4044	PROCEDURE CODE/AGE CONFLICT	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
4045	NO REIMBURSEMENT RULE FOR ASSOCIATED BENEFIT PLAN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N180	This item or service does not meet the criteria for the category under which it was billed.	CO
4046	PROCEDURE CODE NOT ALLOWED FOR DATE OF SERVICE	181	Payment adjusted because this procedure code was invalid on the date of service	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4052	ADMIT DIAGNOSIS NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA65	Missing/incomplete/invalid admitting diagnosis.	CO
4061	NO REIMBURSEMENT RULE FOR ASSOCIATED CLAIM TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N180	This item or service does not meet the criteria for the category under which it was billed.	CO
4062	NO REIMBURSEMENT RULE FOR ASSOCIATED CONDITION CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
4068	NO REIMB RULE FOR ASSOCIATED CONTRACT	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M139	Denied services exceed the coverage limit for the demonstration.	CO
4070	INVALID MODIFIER FOR REIMBURSEMENT RULE	182	Payment adjusted because the procedure modifier was invalid on the date of service	N519	Invalid combination of HCPCS modifiers.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4072	NO REIMBURSEMENT RULE FOR ASSOCIATED DIAGNOSIS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
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. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M50	Missing/incomplete/invalid revenue code(s).	CO
4078	ERFLAT EXEMPTION INDICATOR DOES NOT MATCH A REIMBURSEMENT RULE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N180	This item or service does not meet the criteria for the category under which it was billed.	CO
4079	CURRENT ATTACHMENT DOES NOT MATCH A REIMBURSEMENT RULE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4080	DIAGNOSIS EMERGENCY INDICATOR DOES NOT MATCH A REIMBURSEMENT RULE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4081	PROVIDERS COUNTY DOES NOT MATCH A REIMBURSEMENT RULE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N521	Mismatch between the submitted provider information and the provider information stored in our system.	CO
4082	MEMBERS COUNTY DOES NOT MATCH A REIMBURSEMENT RULE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N30	Patient ineligible for this service.	CO
4086	INDEPENDENT LAB NOT CERTIFIED	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA120	Missing/incomplete/invalid CLIA certification number.	CO
4087	NDC DOES NOT MATCH A PROVIDER CONTRACT RULE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N521	Mismatch between the submitted provider information and the provider information stored in our system.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4088	NDC DOES NOT MATCH A REIMBURSEMENT RULE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
4089	MISSING/INVALID HCPCS SURGICAL CDE/SURGERY REV CDE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
4093	DIAGNOSIS NOT VALID FOR MEMBER BENEFIT PLAN ROLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4095	NONSURGICAL SERV NOT REIMBURSED TO NON - ASC PROV	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA109	Claim processed in accordance with ambulatory surgical guidelines.	CO
4098	HEADER PAID AMOUNT IS GREATER THAN BILLED AMOUNT	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4105	NO/PARTIAL REVENUE RATE SEGMENT FOR REVENUE CODE DATES OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M50	Missing/incomplete/invalid revenue code(s).	CO
4106	NO PROVIDER DRG RATE FOR DATE OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
4107	REVENUE CODE IS NOT COVERED AS BILLED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M50	Missing/incomplete/invalid revenue code(s).	CO
4108	PROVIDER CHARGE RECORD/ CMO PHP RECORD NOT FOUND	147	Provider contracted/negotiated rate expired or not on file.	N59	Please refer to your provider manual for additional program and provider information.	CO
4113	UNIT DOSE PACKAGING COVERED FOR LTC RESIDENTS ONLY	58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.	CO
4114	NO GPCI ON FILE	58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
4115	NO RBRVS CONVERSION FACTOR	147	Provider contracted/negotiated rate expired or not on file.	N203	Missing/incomplete/invalid anesthesia time/units	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4121	PROCEDURE CODE REQUIRES QUADRANT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N346	Missing/incomplete/invalid oral cavity designation code.	CO
4122	VALUE CODE IS INVALID	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M49	Missing/incomplete/invalid value code(s) or amount(s).	CO
4123	VALUE CODE AMOUNT IS MISSING	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M49	Missing/incomplete/invalid value code(s) or amount(s).	CO
4124	VALUE CODE AMOUNT IS INVALID	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M49	Missing/incomplete/invalid value code(s) or amount(s).	CO
4125	THE FIRST VALUE CODE IS INVALID FOR HOSPICE CLAIM	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M49	Missing/incomplete/invalid value code(s) or amount(s).	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4126	TOOTH QUADRANT/PROCEDURE CODE COMBINATION INVALID	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N39	Procedure code is not compatible with tooth number/letter.	CO
4127	CANNOT PRIORITIZE MEMBERS PROGRAMS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N30	Patient ineligible for this service.	CO
4128	ADMISSION DATE IS AFTER FROM DATE OF SERVICE	133	The disposition of this claim/service is pending further review.	MA40	Missing/incomplete/invalid admission date.	PI
4129	THE DISCHARGE HOUR IS MISSING OR INVALID	133	The disposition of this claim/service is pending further review.	N317	Missing/incomplete/invalid discharge hour.	PI
4131	NO BENEFIT PLANS ASSOCIATED TO PAYER	204	This service/equipment/drug is not covered under the patient&#65533;s current benefit plan	N30	Patient ineligible for this service.	CO
4132	DRG GROUPER UNABLE TO ASSIGN DRG FOR PRICING	A8	Claim denied; ungroupable DRG	N208	Missing/incomplete/invalid DRG code	CO
4134	DRG GRPR NOT ABLE TO GROUP WITH INFO PROVIDED	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N208	Missing/incomplete/invalid DRG code	CO
4135	APC GROUPER UNABLE TO GROUP/PRICE	A8	Claim denied; ungroupable DRG	N208	Missing/incomplete/invalid DRG code	CO
4137	PERF PT/PS RESTRICTION FOR COVERED ICD	185	The rendering provider is not eligible to perform the service billed.	N95	This provider type/provider specialty may not bill this service.	CO
4138	BILLING PT/PS RESTRICTION FOR COVERED NDC	87	Transfer amount.	N95	This provider type/provider specialty may not bill this service.	OA
4139	PERF PT/PS RESTRICTION FOR COVERED NDC	185	The rendering provider is not eligible to perform the service billed.	N95	This provider type/provider specialty may not bill this service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4140	PAY-TO PROVIDER TYPE INVALID FOR PROCEDURE CODE	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	N95	This provider type/provider specialty may not bill this service.	CO
4141	PERF PT/PS RESTRICTION FOR COVERED PROCEDURE	185	The rendering provider is not eligible to perform the service billed.	N95	This provider type/provider specialty may not bill this service.	CO
4142	REVENUE CODE NOT ALLOWED FOR DIALYSIS PROVIDER	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N95	This provider type/provider specialty may not bill this service.	CO
4143	PERF PT/PS RESTRICTION FOR COVERED REV CODE	185	The rendering provider is not eligible to perform the service billed.	N95	This provider type/provider specialty may not bill this service.	CO
4144	PERF PT/PS RESTRICTION FOR BILLED DIAGNOSIS	12	The diagnosis is inconsistent with the provider type.	N95	This provider type/provider specialty may not bill this service.	CO
4145	BILL PROV TYPE SPEC NOT VALID FOR CONTRACT - DRG	87	Transfer amount.	N95	This provider type/provider specialty may not bill this service.	OA
4146	PERF PT/PS RESTRICTION FOR BILLED DRG	185	The rendering provider is not eligible to perform the service billed.	N95	This provider type/provider specialty may not bill this service.	CO
4147	PERF PT/PS RESTRICTION FOR BILLED ICD	185	The rendering provider is not eligible to perform the service billed.	N95	This provider type/provider specialty may not bill this service.	CO
4148	PERF PT/PS RESTRICTION FOR BILLED NDC	185	The rendering provider is not eligible to perform the service billed.	N95	This provider type/provider specialty may not bill this service.	CO
4149	PROCEDURE RESTRICTED TO CERTAIN SPECIALTY(IES). PROVIDER NOT ENROLLED	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	N95	This provider type/provider specialty may not bill this service.	CO
4150	PERFORMING/FACILITY PT/PS RESTRICTION ON PROC BILL	185	The rendering provider is not eligible to perform the service billed.	N95	This provider type/provider specialty may not bill this service.	CO
4151	REVENUE CODE NOT ALLOWED FOR DIALYSIS PROVIDER	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N95	This provider type/provider specialty may not bill this service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4152	PERF PT/PS RESTRICTION FOR BILLED REV CODE	185	The rendering provider is not eligible to perform the service billed.	N95	This provider type/provider specialty may not bill this service.	CO
4153	MEDICAL REVIEW REQUIRED FOR BILLED NDC	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4155	NO REIMB RULE FOR ASSOCIATED POS	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M77	Missing/incomplete/invalid place of service.	CO
4157	CONTRACT RESTRICTION FOR BILLED DIAGNOSIS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4158	CONTRACT RESTRICTION FOR BILLED DRG	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N208	Missing/incomplete/invalid DRG code	CO
4159	CONTRACT RESTRICTION FOR BILLED ICD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4160	CONTRACT RESTRICTION FOR BILLED NDC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
4161	CONTRACT RESTRICTION FOR BILLED PROCEDURE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
4162	INVALID HOSPICE REVENUE CODE OR INVALID COMBINATION OF HOSPICE REVENUE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M50	Missing/incomplete/invalid revenue code(s).	CO
4164	INACTIVE DRUG	11	The diagnosis is inconsistent with the procedure.	N79	Service billed is not compatible with patient location information.	CO
4165	MAX DAY RESTRICTION FOR COVERED NDC	11	The diagnosis is inconsistent with the procedure.	N79	Service billed is not compatible with patient location information.	CO
4167	TOTAL PAID AMOUNT CANNOT EXCEED $3,120 PER MEMBER PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
4181	ENCOUNTER BLANKET DENIAL	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N59	Please refer to your provider manual for additional program and provider information.	CO
4190	REFERRING PROVIDER REQUIRED FOR BILLED DRG	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N286	Missing/incomplete/invalid referring provider primary identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4191	REFERRING PROVIDER REQUIRED FOR BILLED ICD	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N286	Missing/incomplete/invalid referring provider primary identifier.	CO
4192	REFERRING PROVIDER REQUIRED FOR BILLED NDC	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N286	Missing/incomplete/invalid referring provider primary identifier.	CO
4193	REFERRING PROVIDER REQUIRED FOR BILLED PROCEDURE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N286	Missing/incomplete/invalid referring provider primary identifier.	CO
4194	REFERRING PROVIDER REQUIRED FOR BILLED REV CODE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N286	Missing/incomplete/invalid referring provider primary identifier.	CO
4196	PROCEDURE RESTRICTION FOR BILLED REV CODE	199	Revenue code and Procedure code do not match.	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
4201	OLD ANESTHESIA NEW MODIFIER CONFLICT	182	Payment adjusted because the procedure modifier was invalid on the date of service	N59	Please refer to your provider manual for additional program and provider information.	CO
4203	DENIAL MODIFIER SUBMITTED ON CLAIM	182	Payment adjusted because the procedure modifier was invalid on the date of service	N519	Invalid combination of HCPCS modifiers.	CO
4204	NO REIMB RULE FOR ASSOCIATED DISCHARGE DATE	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N318	Missing/incomplete/invalid discharge or end of care date.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4206	UNITS RESTRICTION FOR PROCEDURE ON BILLING RULE	222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
4208	NO CLIA REGISTRATION ON FILE FOR THIS PROVIDER	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA120	Missing/incomplete/invalid CLIA certification number.	CO
4210	REIMBURSEMENT AGREEMENT - REVENUE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M50	Missing/incomplete/invalid revenue code(s).	CO
4212	CLAIM IS BEING ADJUSTED-PRE-OP CARE BY NON-OP PROVIDER	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N59	Please refer to your provider manual for additional program and provider information.	OA
4213	RE-USED NDC CODES	133	The disposition of this claim/service is pending further review.	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	PI
4215	MODIFIER REQUIRES DCH REVIEW	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N35	Program integrity/utilization review decision.	CO
4218	NOT USED - WAIVER PROCEDURE	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
4219	NO REIMB RULE FOR ASSOCIATED TOB	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA30	Missing/incomplete/invalid type of bill.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4222	MED REVIEW RESTRICTION FOR COVERED NDC	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4223	PROCEDURE REQUIRES MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4224	MINIMUM UNIT RESTRICTION FOR COVERED PROC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M53	Missing/incomplete/invalid days or units of service.	CO
4225	INPATIENT CLAIM MUST BE BILLED WITH AN ACCOMMODATION REVENUE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M50	Missing/incomplete/invalid revenue code(s).	CO
4227	MEMBER PLAN RESTRICTION FOR BILLED REVENUE CODE	204	This service/equipment/drug is not covered under the patient&#65533;s current benefit plan	M50	Missing/incomplete/invalid revenue code(s).	CO
4229	DIAGNOSIS REQUIRES MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4231	MAXIMUM UNIT RESTRICTION FOR COVERED NDC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4234	NO REIMB RULE FOR ASSOCIATED PATIENT STATUS	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA43	Missing/incomplete/invalid patient status.	CO
4237	INVALID TYPE OF LEAVE FOR LTC CLAIM	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N180	This item or service does not meet the criteria for the category under which it was billed.	CO
4238	CO-INSURANCE AMOUNT EXCEEDS MEDICARE ALLOWED FOR CALENDAR YEAR BILLED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N524	Based on policy this payment constitutes payment in full.	CO
4239	NO PAYMENT DUE FROM MEDICAID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N524	Based on policy this payment constitutes payment in full.	CO
4245	ADJUSTMENT PAID AMOUNT IS LESS THAN ZERO	193	Original payment decision is being maintained. This claim was processed properly the first time.	N377	Payment adjusted based on a processed replacement claim.	CO
4246	ADJUSTMENT NET PAID AMOUNT EXCEEDS THE CASH RECEIPT BALANCE	147	Provider contracted/negotiated rate expired or not on file.	N377	Payment adjusted based on a processed replacement claim.	CO
4247	CATASTROPHIC DME PROCEDURE CODE E1399 IS NOT PAYABLE AFTER 03/31/2008	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4249	MAX UNIT RESTRICTION FOR BILLED PROC	222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
4250	NO REIMB RULE FOR ASSOCIATED PT/PS	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	M95	Services subjected to Home Health Initiative medical review/cost report audit.	CO
4251	DECIMAL UNITS NOT BILLABLE FOR PROCEDURE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	M53	Missing/incomplete/invalid days or units of service.	CO
4252	CLAIM TYPE RESTRICTION FOR COVERED DIAGNOSIS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4253	POS RESTRICTION FOR COVERED NDC	58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	N428	Service/procedure not covered when performed in this place of service.	CO
4254	PLACE OF SERVICE IS NOT ALLOWED FOR NDC	58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	M77	Missing/incomplete/invalid place of service.	CO
4256	INVALID MODIFIER FOR COVERED PROCEDURE	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	N519	Invalid combination of HCPCS modifiers.	CO
4257	INVALID PROCEDURE CODE MODIFIER	182	Payment adjusted because the procedure modifier was invalid on the date of service	N519	Invalid combination of HCPCS modifiers.	CO
4258	SECONDARY DIAG RESTRICTION FOR BILLED NDC	167	This (these) diagnosis(es) is (are) not covered.	N95	This provider type/provider specialty may not bill this service.	CO
4271	PRIMARY DIAGNOSIS REQUIRES DCH MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4272	CLAIM SUSPENDED FOR DCH REVIEW OF 2ND BILLED DIAG	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N35	Program integrity/utilization review decision.	CO
4273	CLAIM SUSPENDED FOR DCH REVIEW OF 3RD BILLED DIAG	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N35	Program integrity/utilization review decision.	CO
4274	CLAIM SUSPENDED FOR DCH REVIEW OF 4TH BILLED DIAG	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N35	Program integrity/utilization review decision.	CO
4275	CLAIM SUSPENDED FOR DCH REVIEW OF 5TH BILLED DIAG	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N35	Program integrity/utilization review decision.	CO
4276	1ST SURG PROC BILLED REQUIRES DCH REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4277	2nd SURG PROC BILLED REQUIRES DCH REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4278	3rd SURG PROC BILLED REQUIRES DCH REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4279	4TH SURG PROC BILLED REQUIRES DCH REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4280	5th SURG PROC BILLED REQUIRES DCH REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4281	6th SURG PROC BILLED REQUIRES DCH REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4301	CLAIM SUSPENDED FOR DCH REVIEW OF 6TH-24TH BILLED DIAG	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N35	Program integrity/utilization review decision.	CO
4302	7th-24th SURG PROC BILLED REQUIRES DCH REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4310	PRIMARY HDR DIAG RESTRICTION FOR COVERED PROC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4311	PRIMARY HDR DIAG RESTRICTION FOR BILLED PROC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4312	PROCEDURE CODE INCOMPATIBLE WITH DIAGNOSIS CODE	11	The diagnosis is inconsistent with the procedure.	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
4313	PROCEDURE INCOMPATIBLE WITH SECONDARY DIAGNOSIS	11	The diagnosis is inconsistent with the procedure.	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
4315	PROCEDURE CODE INCOMPATIBLE WITH DIAGNOSIS CODE	11	The diagnosis is inconsistent with the procedure.	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
4316	PROCEDURE CODE INCOMPATIBLE WITH DIAGNOSIS CODE	11	The diagnosis is inconsistent with the procedure.	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4317	ADMIT DIAG RESTRICTION FOR BILLED ICD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA65	Missing/incomplete/invalid admitting diagnosis.	CO
4318	PRIMARY HDR DIAG RESTRICTION FOR BILLED ICD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4319	ANY HDR DIAG RESTRICTION FOR BILLED ICD	11	The diagnosis is inconsistent with the procedure.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4320	ADMIT DIAG RESTRICTION FOR BILLED REVENUE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA65	Missing/incomplete/invalid admitting diagnosis.	CO
4321	PRIMARY HDR DIAG RESTRICTION FOR BILLED REVENUE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4322	ANY HDR DIAG RESTRICTION FOR BILLED REV CODE	11	The diagnosis is inconsistent with the procedure.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4324	ADMIT DIAGNOSIS IS NOT SPECIFIC	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4325	ADMIT DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4326	EXTERNAL CAUSE DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4327	PATIENT REASON DIAGNOSIS IS A HEADER OR PARENT CODE	167	This (these) diagnosis(es) is (are) not covered.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4341	COVERED PROCEDURE REQUIRES DCH MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4342	COVERED DRUG REQUIRES DCH MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4343	COVERED REVENUE CODE REQUIRES DCH MED REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4344	COVERED DRG REQUIRES DCH MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4345	PROCEDURE REQUIRES DCH MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4346	DRUG BILLED REQUIRES DCH MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4348	REVENUE CODE REQUIRES DCH MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4349	DRG BILLED REQUIRES DCH MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4350	COVERED DIAGNOSIS REQUIRES DCH MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4351	ICD PROCEDURE REQUIRES DCH MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4352	DIAGNOSIS REQUIRES DCH MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4353	ICD PROCEDURE REQUIRES DCH MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4354	VALUE CODE 61 RESTRICTION NOT MET	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M49	Missing/incomplete/invalid value code(s) or amount(s).	CO
4355	ANESTHESIA CONVERSION FACTOR (ACF) MODIFIER REQUIRED FOR ANESTHESIA PR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N519	Invalid combination of HCPCS modifiers.	CO
4356	DIAGNOSIS RESTRICTION FOR PROCEDURE REIMBURSEMENT RULE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4357	DOCUMENTATION SUBMITTED DOES NOT MEET THE FEDERAL DEFINITION OF AN EME	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N19	Procedure code incidental to primary procedure.	OA
4358	SUPPORTING DOCO WAS INSUFFICIENT TO SUPPORT AN EMERGENCY. RESUBMIT WIT	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N19	Procedure code incidental to primary procedure.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4361	PRIMARY DIAG RESTRICTION FOR COVERED NDC	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4362	TYPE OF BILL RESTRICTION FOR BILLED DIAGNOSIS	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA30	Missing/incomplete/invalid type of bill.	CO
4363	TYPE OF BILL RESTRICTION FOR BILLED DRG	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA30	Missing/incomplete/invalid type of bill.	CO
4364	TYPE OF BILL RESTRICTION FOR BILLED ICD	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA30	Missing/incomplete/invalid type of bill.	CO
4366	RESUBMIT WITH MEDICAL JUSTIFICATION FOR AN INPATIENT ADMISSION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N358	This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4367	NO MEDICAL JUSTIFICATION FOR AN INPATIENT ADMISSION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N29	Missing documentation/orders/notes/summary/report/chart. (Modified 2/28/03, 8/1/05) Related to N225	CO
4368	TYPE OF BILL RESTRICTION FOR BILLED PROCEDURE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA30	Missing/incomplete/invalid type of bill.	CO
4371	CLAIM TYPE RESTRICTION FOR COVERED PROCEDURE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N34	Incorrect claim form/format for this service.	CO
4373	CLAIM TYPE RESTRICTION FOR COVERED NDC	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N34	Incorrect claim form/format for this service.	CO
4374	CLAIM TYPE RESTRICTION FOR COVERED REV CODE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N34	Incorrect claim form/format for this service.	CO
4375	NO REIMB RULE FOR PROVIDER LOCATION	147	Provider contracted/negotiated rate expired or not on file.	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4376	CLAIM TYPE RESTRICTION FOR COVERED ICD	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N34	Incorrect claim form/format for this service.	CO
4380	PROCEDURE IS NEEDED FOR REVENUE MAXFEE PRICING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M67	Missing/incomplete/invalid other procedure code(s). (Modified 12/2/04) Related to N302	CO
4381	UNABLE TO DETERMINE PRICING METHOD FOR DETAIL	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
4383	INVALID MODIFIER/REVENUE CODE COMBINATION	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	N519	Invalid combination of HCPCS modifiers.	CO
4384	DIAGNOSIS IS NOT A PRINCIPAL DIAGNOSIS	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4388	AGE RESTRICTION FOR BILLED DRG	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N208	Missing/incomplete/invalid DRG code	CO
4389	INVALID MEMBER SEX FOR DRG ASSIGNED	7	The procedure/revenue code is inconsistent with the patient's gender.	MA39	Missing/incomplete/invalid gender.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4390	INVALID DISCHARGE STATUS FOR DRG ASSIGNMENT	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N208	Missing/incomplete/invalid DRG code	CO
4391	DRG GROUPER INVALID LENGTH OF STAY	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N208	Missing/incomplete/invalid DRG code	CO
4393	INVALID REVENUE CODE/PROCEDURE CODE COMBINATION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA50	Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.	CO
4394	UNABLE TO ASSIGN REG CT FOR CROSSOVER PRICING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N180	This item or service does not meet the criteria for the category under which it was billed.	CO
4395	RECORD DOESNT MEET ANY DRG CRITERIA	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA63	Missing/incomplete/invalid principal diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4396	DRG INVALID MEMBER DISCHARGE AGE IN DAYS	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N208	Missing/incomplete/invalid DRG code	CO
4397	ILLOGICAL PRINCIPAL DIAGNOSIS FOR DRG ASSIGNMENT	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4398	INVALID PRINCIPAL DIAGNOSIS FOR ASSIGNING A DRG	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4399	DRG CLM QUALIFIES AS OUTLIER	70	Cost outlier - Adjustment to compensate for additional costs.	N59	Please refer to your provider manual for additional program and provider information.	OA
4400	INTERIM BILL DOES NOT MEET THE COVERED DAYS REQUIREMENT	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA32	Missing/incomplete/invalid number of covered days during the billing period.	CO
4401	ADMIT DIAGNOSIS INVALID RETURNED FROM GROUPER	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA65	Missing/incomplete/invalid admitting diagnosis.	CO
4402	PRINCIPAL DIAGNOSIS INVALID RETURNED FROM GROUPER	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA63	Missing/incomplete/invalid principal diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4403	PRINCIPAL DIAGNOSIS SEX CONFLICT RETURNED FROM GROUPER	10	The diagnosis is inconsistent with the patient's gender.	MA39	Missing/incomplete/invalid gender.	CO
4404	PRINCIPAL DIAGNOSIS AGE CONFLICT RETURNED FROM GROUPER	9	The diagnosis is inconsistent with the patient's age.	N208	Missing/incomplete/invalid DRG code	CO
4405	E-CODE AS PRINCIPAL DIAGNOSIS RETURNED FROM GROUPER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4406	PRINCIPAL DIAGNOSIS NOT SPECIFIC RETURNED FROM GROUPER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4407	MANIFESTATION AS PRINCIPAL DIAGNOSIS RETURNED FROM GROUPER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4408	PRINCIPAL DIAGNOSIS UNACCEPTABLE RETURNED FROM GROUPER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4409	PRINCIPAL DIAGNOSIS REQUIRES SECONDARY DIAGNOSIS RETURNED FROM GROUPER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4410	SECONDARY DIAGNOSIS INVALID RETURNED FROM GROUPER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4411	SECONDARY DIAGNOSIS SEX CONFLICT RETURNED FROM GROUPER	10	The diagnosis is inconsistent with the patient's gender.	MA39	Missing/incomplete/invalid gender.	CO
4412	SECONDARY DIAGNOSIS DUPLICATE OF PRINCIPAL DIAGNOSIS RETURNED FROM GROUPER	10	The diagnosis is inconsistent with the patient's gender.	MA39	Missing/incomplete/invalid gender.	CO
4413	SECONDARY DIAGNOSIS AGE CONFLICT RETURNED FROM GROUPER	9	The diagnosis is inconsistent with the patient's age.	N208	Missing/incomplete/invalid DRG code	CO
4414	ICD PROCEDURE INVALID RETURNED FROM GROUPER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
4415	PROCEDURE NOT ALLOWED WITH S5102	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4416	ICD PROCEDURE BILATERAL RETURNED FROM GROUPER	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
4417	ICD PROCEDURE INCONSISTENT WITH LENGTH OF STAY RETURNED FROM GROUPER	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N208	Missing/incomplete/invalid DRG code	CO
4423	NON EMERGENCY SERVICES ARE NOT PAYABLE FOR UNDOCUMENTED ALIENS	31	Claim denied as patient cannot be identified as our insured.	N30	Patient ineligible for this service.	CO
4424	SERVICES INCLUDED IN NH PER DIEM RATE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N525	These services are not covered when performed within the global period of another services.	OA
4431	TOTAL COST OF REPAIR IS GREATER THAN PURCHASE PRICE	108	Payment adjusted because rent/purchase guidelines were not met.	N171	Payment for repair or replacement is not covered or has exceeded the purchase price.	CO
4444	SYSTEM ERROR - MULTIPLE RULES PASSED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
4450	MEMBER HAS ELECTED TO RECEIVE HOSPICE SERVICE. HOSPICE RELATED SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N30	Patient ineligible for this service.	CO
4486	MEMBER ID NOT FOUND AND CLAIM OVER 15 DAYS OLD	140	Patient/Insured health identification number and name do not match.	N382	Missing/incomplete/invalid patient identifier.	CO
4515	ICD PROCEDURE SEX CONFLICT RETURNED FROM GROUPER	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4600	FACILITY NPI REQUIRED WHEN POS IS WITHIN FACILITY- HDR	206	NPI denial - Missing. This change to be effective 4/1/2008: National Provider Identifier - missing.	N433	Resubmit this claim using only your National Provider Identifier (NPI)	CO
4601	FACILITY NPI REQUIRED WHEN POS IS WITHIN FACILITY- DTL	206	NPI denial - Missing. This change to be effective 4/1/2008: National Provider Identifier - missing.	N433	Resubmit this claim using only your National Provider Identifier (NPI)	CO
4602	FACILITY NPI IS NOT VALID - HDR	208	NPI denial - not matched. This change to be effective 4/1/2008: National Provider Identifier - Not matched.	N516	Records indicate a mismatch between the submitted NPI and EIN.	CO
4603	FACILITY NPI IS NOT VALID - DTL	208	NPI denial - not matched. This change to be effective 4/1/2008: National Provider Identifier - Not matched.	N516	Records indicate a mismatch between the submitted NPI and EIN.	CO
4604	HAC NEVER EVENT MODIFIER NOT ALLOWED	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	N516	Records indicate a mismatch between the submitted NPI and EIN.	CO
4605	HAC DIAGNOSIS NOT ALLOWED - HDR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4606	NEVER EVENT PRESENT ON TOB 110	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA30	Missing/incomplete/invalid type of bill.	CO
4607	HAC DIAGNOSIS NOT ALLOWED - DTL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4711	DIAGNOSIS INCOMPATIBLE FOR MEMBERS AGE. ENSURE A NEWBORN-ONLY DIAG CO	9	The diagnosis is inconsistent with the patient's age.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
4714	AGE TO PROCEDURE CODE CONFLICT	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
4715	PROCEDURE CODE/AGE CONFLICT	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
4716	AGE RESTRICTION FOR BILLED ICD	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
4721	ADMIT DIAG RESTRICTION FOR BILLED DRG	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA65	Missing/incomplete/invalid admitting diagnosis.	CO
4722	PRIMARY HDR DIAG RESTRICTION FOR COVERED DRG	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4723	PRIMARY HDR DIAG RESTRICTION FOR COVERED ICD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4724	DIAG RESTRICTION FOR COVERED ICD	11	The diagnosis is inconsistent with the procedure.	MA63	Missing/incomplete/invalid principal diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4726	ADMIT DIAG RESTRICTION FOR BILLED ICD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA65	Missing/incomplete/invalid admitting diagnosis.	CO
4730	ANY HDR DIAG RESTRICTION FOR COVERED PROC	11	The diagnosis is inconsistent with the procedure.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4732	REVENUE CODE INVALID FOR DIAGNOSIS CODE	11	The diagnosis is inconsistent with the procedure.	N59	Please refer to your provider manual for additional program and provider information.	CO
4733	ANY HDR DIAG RESTRICTION FOR COVERED REV CODE	11	The diagnosis is inconsistent with the procedure.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4734	PRIMARY HDR DIAG RESTRICTION FOR BILLED DRG	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4736	PRIMARY HDR DIAG RESTRICTION FOR COVERED REV CDE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4742	ADMIT DIAG RESTRICTION FOR BILLED PROC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA65	Missing/incomplete/invalid admitting diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4753	POA INDICATOR OF N, U, W, OR Y NOT ALLOWED FOR PRIMARY DIAGNOSIS	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N35	Program integrity/utilization review decision.	CO
4754	POA INDICATOR MISSING	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N35	Program integrity/utilization review decision.	CO
4755	HAC PRESENT AT ADMISSION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N35	Program integrity/utilization review decision.	CO
4756	HOSPITAL ACQUIRED CONDITIONS POSSIBLY PRESENT AT ADMISSION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N35	Program integrity/utilization review decision.	CO
4757	HOSPITAL ACQUIRED CONDITIONS PRESENT AT ADMISSION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N35	Program integrity/utilization review decision.	CO
4758	ADJUSTMENT-POA INDICATOR CHANGE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N35	Program integrity/utilization review decision.	CO
4759	CLAIM CONTAINS NO INDICATION OF UNUSUAL PROCEDURAL SERVICE	133	The disposition of this claim/service is pending further review.	N102	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	PI
4760	ICD PROCEDURE REQUIRES MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4762	POS RESTRICTION FOR BILLED ICD	5	The procedure code/bill type is inconsistent with the place of service.	N428	Service/procedure not covered when performed in this place of service.	CO
4767	POS RESTRICTION FOR COVERED ICD	5	The procedure code/bill type is inconsistent with the place of service.	N428	Service/procedure not covered when performed in this place of service.	CO
4768	ICD PROCEDURE REQUIRES MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4776	DIAGNOSIS NOT COVERED	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
4798	SUBMITTED CHARGE IS NOT EVENLY DIVISIBLE BY UNITS OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4801	THESE SERVICES CANNOT BE BILLED ON THIS CLAIM FORM OR THE PROVIDER TYP	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N34	Incorrect claim form/format for this service.	CO
4802	NO CONTRACT FOR BILLED DIAGNOSIS	167	This (these) diagnosis(es) is (are) not covered.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
4804	REVENUE CODE OR SERVICE INFORMATION CONFLICT FOR THE PROVIDER	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M50	Missing/incomplete/invalid revenue code(s).	CO
4806	NO CONTRACT FOR BILLED ICD PROCEDURE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M64	Missing/incomplete/invalid other diagnosis.	CO
4812	DIAGNOSIS REQUIRES MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4813	PROCEDURE REQUIRES MEDICAL REVIEW BY FISCAL AGENT	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4814	REVENUE CODE REQUIRES MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4815	7TH, 8TH, OR 9TH DIAGNOSIS CODE NOT COVERED	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
4818	7TH, 8TH, OR 9TH DIAGNOSIS CODE NOT BILLED	167	This (these) diagnosis(es) is (are) not covered.	M64	Missing/incomplete/invalid other diagnosis.	CO
4821	PLACE OF SERVICE RESTRICTION ON PROC BILLING RULE	5	The procedure code/bill type is inconsistent with the place of service.	N428	Service/procedure not covered when performed in this place of service.	CO
4822	POS RESTRICTION FOR BILLED DIAGNOSIS	5	The procedure code/bill type is inconsistent with the place of service.	N428	Service/procedure not covered when performed in this place of service.	CO
4823	TOOTH NUMBER RESTRICTION NOT MET	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N37	Missing/incomplete/invalid tooth number/letter.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4831	NO REIMBURSEMENT RULE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
4834	REV CODE PROV TYPE/SPEC RESTRICTION	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N95	This provider type/provider specialty may not bill this service.	CO
4835	DRG PROV TYPE/SPEC RESTRICTION	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N95	This provider type/provider specialty may not bill this service.	CO
4845	MEDICAL REVIEW REQUIRED FOR BILLED DRG	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4846	PRIMARY COVERED DIAGNOSIS REQUIRES DCH MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4847	2ND COVERED DIAGNOSIS REQUIRES DCH MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4848	3RD COVERED DIAGNOSIS REQUIRES DCH MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4849	4TH COVERED DIAGNOSIS REQUIRES DCH MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4850	5TH COVERED DIAGNOSIS REQUIRES DCH MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4851	1ST ICD SURG PROC COVERED REQUIRES DCH REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4852	2ND ICD SURG PROC COVERED REQUIRES DCH REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4853	3RD ICD SURG PROC COVERED REQUIRES DCH REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4854	4TH ICD SURG PROC COVERED REQUIRES DCH REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4855	5TH ICD SURG PROC COVERED REQUIRES DCH REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4856	6TH ICD SURG PROC COVERED REQUIRES DCH REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4857	PRIMARY DIAGNOSIS REQUIRES MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4858	SECONDARY DIAGNOSIS REQUIRES MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4860	THIRD DIAGNOSIS REQUIRES MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4866	4TH DIAG CODE REQUIRES MED REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4867	5TH DIAG CODE REQUIRES MED REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4871	PROCEDURE CODE NOT COVERED FOR CLAIM TYPE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N34	Incorrect claim form/format for this service.	CO
4872	CLAIM TYPE RESTRICTION FOR BILLED DIAGNOSIS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4873	CLAIM TYPE RESTRICTION FOR BILLED NDC	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N34	Incorrect claim form/format for this service.	CO
4874	OUTPATIENT REV CODE NOT ON FILE OR NOT COVERED - IF REV CODE IS IN THE	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N152	Missing/incomplete/invalid replacement claim information.	CO
4875	CLAIM TYPE RESTRICTION FOR BILLED DRG	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N34	Incorrect claim form/format for this service.	CO
4876	CLAIM TYPE RESTRICTION FOR BILLED ICD	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N34	Incorrect claim form/format for this service.	CO
4881	POS RESTRICTION FOR BILLED DRG	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M77	Missing/incomplete/invalid place of service.	CO
4882	NO COVERAGE FOR BILLED DRG	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N208	Missing/incomplete/invalid DRG code	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4883	MEDICAL REVIEW REQUIRED FOR COVERED DRG	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4886	CLAIM TYPE RESTRICTION FOR COVERED DRG	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N34	Incorrect claim form/format for this service.	CO
4887	POS RESTRICTION FOR COVERED DRG	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M77	Missing/incomplete/invalid place of service.	CO
4888	THE NATIONAL DRUG CODE IS REQUIRED WITH AN INJECTABLE DRUG PROC CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
4889	THE NATIONAL DRUG CODE DOES NOT MATCH THE INJECTABLE DRUG PROC CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4890	THE NATIONAL DRUG CODE IS REQUIRED WITH REVENUE CODE 259	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
4891	UNITS ASSOCIATED WITH THE NDC QUANTITY ARE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
4895	6TH-24TH COVERED DIAG CODE REQUIRES DCH REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4896	7TH-24TH SURG PROC COVERED REQUIRES DCH REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4898	FIRST SURGICAL PROCEDURE REQUIRES MEDICAL REVIEW	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N35	Program integrity/utilization review decision.	CO
4899	SECOND SURGICAL PROCEDURE REQUIRES MEDICAL REVIEW	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N35	Program integrity/utilization review decision.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4901	CONDITION CODE RESTRICTION FOR COVERED DIAGNOSIS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
4902	OCC CDE RESTRICTION FOR COVERED DIAGNOSIS	167	This (these) diagnosis(es) is (are) not covered.	M45	Missing/incomplete/invalid occurrence code(s). (Modified 12/2/04) Related to N299	CO
4903	ADMIT ROLE RESTRICTION ON COVERED DIAGNOSIS	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA41	Missing/incomplete/invalid admission type.	CO
4904	PRIMARY ROLE RESTRICTION ON COVERED DIAGNOSIS	11	The diagnosis is inconsistent with the procedure.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4905	SECONDARY ROLE RESTRICTION ON COVERED DIAGNOSIS	11	The diagnosis is inconsistent with the procedure.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4906	EMERGENCY ROLE RESTRICTION ON COVERED DIAGNOSIS	11	The diagnosis is inconsistent with the procedure.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4907	PROV LOCATION RESTRICTION FOR COVERED DRG	11	The diagnosis is inconsistent with the procedure.	N79	Service billed is not compatible with patient location information.	CO
4908	THIRD SURGICAL PROCEDURE REQUIRES MEDICAL REVIEW	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N35	Program integrity/utilization review decision.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4909	FOURTH SURGICAL PROCEDURE REQUIRES MEDICAL REVIEW	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N35	Program integrity/utilization review decision.	CO
4910	BENEFIT PLAN RESTRICTION FOR BILLED DIAGNOSIS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
4911	CONDITION CODE RESTRICTION FOR BILLED DIAGNOSIS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
4912	OCC CDE RESTRICTION FOR BILLED DIAGNOSIS	167	This (these) diagnosis(es) is (are) not covered.	M45	Missing/incomplete/invalid occurrence code(s). (Modified 12/2/04) Related to N299	CO
4913	DIAGNOSIS ROLE RESTRICTION FOR BILLED BENEFIT ON PROVIDER CONTRACT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4914	FIFTH SURGICAL PROCEDURE REQUIRES MEDICAL REVIEW	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N35	Program integrity/utilization review decision.	CO
4915	SIXTH SURGICAL PROCEDURE REQUIRES MEDICAL REVIEW	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N35	Program integrity/utilization review decision.	CO
4916	7TH-25TH SURGICAL PROCEDURE REQUIRES MEDICAL REVIEW	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N35	Program integrity/utilization review decision.	CO
4917	PROV LOCATION RESTRICTION FOR COVERED DRG	11	The diagnosis is inconsistent with the procedure.	N79	Service billed is not compatible with patient location information.	CO
4918	MEDICAL REVIEW REQUIRED - SOBRA	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
4919	MEMBER HAS MORE THAN ONE LIABILITY SPAN COVERING THE CLAIM DOS	142	Claim adjusted by the monthly Medicaid patient liability amount.	N58	Missing/incomplete/invalid patient liability amount.	PR

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4920	BENEFIT PLAN RESTRICTION FOR COVERED DRG	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N208	Missing/incomplete/invalid DRG code	CO
4921	CONDITION CODE RESTRICTION FOR COVERED DRG	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
4922	OCC CDE RESTRICTION FOR COVERED DRG	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M45	Missing/incomplete/invalid occurrence code(s). (Modified 12/2/04) Related to N299	CO
4923	GENDER RESTRICTION FOR COVERED ICD	7	The procedure/revenue code is inconsistent with the patient's gender.	MA39	Missing/incomplete/invalid gender.	CO
4924	NON-PPS CONTRACT ON PPS PRICED CLAIM	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO
4925	DIAGNOSIS NOT COVERED FOR BENEFIT PLAN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4926	ICD NOT COVERED FOR BENEFIT PLAN	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
4930	BENEFIT PLAN RESTRICTION FOR BILLED DRG	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N208	Missing/incomplete/invalid DRG code	CO
4931	CONDITION CODE RESTRICTION FOR BILLED DRG	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
4933	GENDER RESTRICTION FOR COVERED ICD	7	The procedure/revenue code is inconsistent with the patient's gender.	MA39	Missing/incomplete/invalid gender.	CO
4935	GENDER RESTRICTION FOR COVERED DRG	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
4936	GENDER RESTRICTION FOR BILLED DRG	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
4939	ATTACHMENT CODE RESTRICTION FOR COVERED ICD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4940	BENEFIT PLAN RESTRICTION FOR COVERED ICD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
4941	CONDITION CODE RESTRICTION FOR COVERED ICD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
4942	OCC CDE RESTRICTION FOR COVERED ICD	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M45	Missing/incomplete/invalid occurrence code(s). (Modified 12/2/04) Related to N299	CO
4943	PROV LOCATION RESTRICTION FOR COVERED NDC	11	The diagnosis is inconsistent with the procedure.	N79	Service billed is not compatible with patient location information.	CO
4946	CLAIM TYPE RESTRICTION FOR REIMBURSEMENT RULE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N34	Incorrect claim form/format for this service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4947	CURRENT ATTACHMENT CODE RESTRICTION FOR REIMBURSEMENT RULE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N180	This item or service does not meet the criteria for the category under which it was billed.	CO
4950	BENEFIT PLAN RESTRICTION FOR BILLED ICD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
4951	CONDITION CODE RESTRICTION FOR BILLED ICD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
4952	OCC CDE RESTRICTION FOR BILLED ICD	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M45	Missing/incomplete/invalid occurrence code(s). (Modified 12/2/04) Related to N299	CO
4960	BENEFIT PLAN RESTRICTION FOR COVERED NDC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4962	PROCEDURE CODE IS INVALID FOR MEMBERS SEX	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
4963	PROCEDURE CODE IS INVALID FOR MEMBERS SEX	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
4964	REVENUE CODE IS NOT COVERED FOR THE MEMBERS SEX	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA39	Missing/incomplete/invalid gender.	CO
4965	BENEFIT PLAN RESTRICTION FOR BILLED NDC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
4966	PROV LOCATION RESTRICTION FOR COVERED PROCEDURE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M77	Missing/incomplete/invalid place of service.	CO
4970	BENEFIT PLAN RESTRICTION FOR COVERED REVENUE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M50	Missing/incomplete/invalid revenue code(s).	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4971	CONDITION CODE RESTRICTION FOR COVERED REVENUE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
4972	OCC CDE RESTRICTION FOR COVERED REV CODE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M45	Missing/incomplete/invalid occurrence code(s). (Modified 12/2/04) Related to N299	CO
4973	CLAIM TYPE RESTRICTION FOR COVERED DRG	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N34	Incorrect claim form/format for this service.	CO
4975	MEMBER PLAN RESTRICTION FOR REV CODE BILLING RULE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
4976	CONDITION CODE RESTRICTION FOR BILLED REVENUE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4977	OCC CDE RESTRICTION FOR BILLED REV CODE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M45	Missing/incomplete/invalid occurrence code(s). (Modified 12/2/04) Related to N299	CO
4979	ATTACHMENT CODE RESTRICTION FOR COVERED PROCEDURE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
4981	CONDITION CODE RESTRICTION FOR COVERED PROCEDURE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
4982	OCC CDE RESTRICTION FOR COVERED PROCEDURE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M45	Missing/incomplete/invalid occurrence code(s). (Modified 12/2/04) Related to N299	CO
4983	PROV LOCATION RESTRICTION FOR COVERED REV CODE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M77	Missing/incomplete/invalid place of service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4988	ICD CODE RESTRICTION FOR COVERED REVENUE CD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
4989	ATTACHMENT CODE RESTRICTION FOR COVERED REVENUE CD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
4990	MEMBER PLAN RESTRICTION FOR PROC BILLING RULE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
4991	CONDITION CODE RESTRICTION FOR BILLED PROCEDURE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M44	Missing/incomplete/invalid condition code.	CO
4992	OCC CDE RESTRICTION FOR BILLED PROCEDURE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M45	Missing/incomplete/invalid occurrence code(s). (Modified 12/2/04) Related to N299	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
4993	PROV LOCATION RESTRICTION FOR COVERED REV CODE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M77	Missing/incomplete/invalid place of service.	CO
4999	THIS DRUG IS NOT COVERED BY MEDICARE PART D	204	This service/equipment/drug is not covered under the patient&#65533;s current benefit plan	N410	This is not covered unless the prescription changes.	CO
5004	DAILY AND 15-MIN COMMUNITY LIVING SUPPORT SERVICES NOT ALLOWED ON THE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5005	COMMUNITY LIVING SUPPORT NOT ALLOWED WITH COMMUNITY RESIDENTIAL ALTERN	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5006	COMMUNITY RESIDENTIAL ALTERNATIVE NOT ALLOWED WITH COMMUNITY LIVING SU	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N59	Please refer to your provider manual for additional program and provider information.	OA
5007	PROCEDURES NOT ALLOWED WITH COMMUNITY RESIDENTIAL ALTERNATIVE SAME DOS	231	Mutually exclusive procedures cannot be done in the same day/setting.	N519	Invalid combination of HCPCS modifiers.	CO
5008	PROCEDURES NOT ALLOWED WITH COMMUNITY RESIDENTIAL ALTERNATIVE SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N59	Please refer to your provider manual for additional program and provider information.	OA
5009	OVERNIGHT RESPITE SERVICES NOT ALLOWED WITH RESPITE SERVICES SAME DAY	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N20	Service not payable with other service rendered on the same date.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5010	DIALYSIS-EXACT DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5011	NATURAL SUPPORT TRAINING SERVICE NOT ALLOWED WITH PROCEDURES	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
5012	PROCEDURES NOT ALLOWED WITH NATURAL SUPPORT TRAINING SERVICE	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
5014	SUSPECT DUPLICATE - HOME HEALTH VERSUS COMMUNITY CARE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5015	SERVICE IS A POSSIBLE DUPLICATE AGAINST MENTAL HEALTH SERVICES	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5016	PROCEDURES NOT COVERED ON SAME OR OVERLAPPING DATES OF SERVICE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N20	Service not payable with other service rendered on the same date.	CO
5017	PROCEDURES ARE NOT ALLOWED ON SAME OR OVERLAPPING DATES OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N20	Service not payable with other service rendered on the same date.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5018	PROCEDURES NOT ALLOWED ON SAME OR OVERLAPPING DATES OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N20	Service not payable with other service rendered on the same date.	CO
5019	PROCEDURES NOT ALLOWED ON SAME OR OVERLAPPING DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N20	Service not payable with other service rendered on the same date.	CO
5020	PROCEDURES NOT COVERED ON SAME OR OVERLAPPING DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N20	Service not payable with other service rendered on the same date.	CO
5021	PROCEDURES NOT COVERED ON SAME OR OVERLAPPING DATES OF SERVICE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N20	Service not payable with other service rendered on the same date.	CO
5022	PROCEDURE CODES NOT PAYABLE ON SAME DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N20	Service not payable with other service rendered on the same date.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5023	PROCEDURE CODES CANNOT BE PAID FOR THE SAME DOS	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
5024	PROCEDURE CODE IS NOT ALLOWED WITH PROCEDURES BILLED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N431	Service is not covered with this procedure.	CO
5025	BILLED PROCEDURES ARE NOT ALLOWED ON THE SAME OR OVERLAPPING DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5026	RESIDENTIAL TRAINING SERVICE CANNOT BE BILLED FOR THE SAME DOS AS RESP	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5027	RESIDENTIAL TRAINING SERVICE CANNOT BE BILLED FOR THE SAME DOS AS RESP	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N20	Service not payable with other service rendered on the same date.	CO
5028	HOME DELIVERED MEALS AND ALTERNATE LIVING SERVICES CANNOT BE BILLED ON	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N20	Service not payable with other service rendered on the same date.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5029	PROCEDURE CODES CANNOT BE REIMBURSED ON THE SAME DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N20	Service not payable with other service rendered on the same date.	CO
5030	MEMBER CANNOT RECEIVE SERVICES SIMULTANEOUSLY UNDER BOTH THE OLD	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5031	CONSUMER DIRECTED PERSONAL SUPPORT SERVICE CANNOT BE BILLED ON THE SAM	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5032	PERSONAL SUPPORT SERVICE CANNOT BE BILLED ON THE SAME OR OVERLAPPING D	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5035	PAID RELATED CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5038	INVALID PROCEDURE/MODIFIER COMBINATION	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	N519	Invalid combination of HCPCS modifiers.	CO
5039	REHAB-EXACT DUPLICATE OF ANOTHER CLAIM	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5040	REHAB-POSSIBLE DUPLICATE OF ANOTHER CLAIM	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5041	REHAB-POSSIBLE CONFLICT WITH ANOTHER CLAIM	B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.	N59	Please refer to your provider manual for additional program and provider information.	CO
5045	HOME HEALTH VISITS HAVE NOT BEEN EXHAUSTED UNDER THE HOME HEALTH PROG	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
5048	EXACT DUPLICATE CLAIM WITH SAME MODIFIER ALREADY PAID	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5049	PROCEDURE CODES NOT ALLOWED ON SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5050	PROCEDURES NON-COVERED ON SAME DOS	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
5051	PROCEDURES NOT ALLOWED ON SAME DATE OF SERVICE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5052	ONE EXTRACTION ALLOWED PER TOOTH	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N362	The number of Days or Units of Service exceeds our acceptable maximum.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5053	NO SEALANT ALLOWED IF TOOTH HAS BEEN EXTRACTED OR RECEIVED RESTORATIVE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.	OA
5054	RESTORATION SERVICES NON-COVERED FOR PREVIOUSLY EXTRACTED TOOTH	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.	CO
5055	RESTORATION NON-COVERED FOR PREVIOUSLY EXTRACTED TOOTH	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.	CO
5056	EMERGENCY; OPEN PULP CHAMBER NOT ALLOWED WHEN ROOT CANAL IS COMPLETE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N525	These services are not covered when performed within the global period of another services.	OA
5057	PROCEDURES NOT ALLOWED FOR THE SAME TOOTH	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.	CO
5058	DENTAL PROCEDURES NOT ALLOWED ON SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5059	D0140 CANNOT BE BILLED ON SAME DOS AS D0130 Or D9440	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5060	ONLY ONE FILLING PER TOOTH ALLOWED ON SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5061	PROCEDURES CANNOT BE BILLED FOR THE SAME DATE OF SERVICE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5062	PROCEDURES CANNOT BE BILLED FOR THE SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5063	SEDATIVE FILLING NOW ALLOWED WITH PROCEDURE CODES BILLED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5064	PROCEDURE CODES BILLED NOT ALLOWED WITH SEDATIVE FILLING	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N431	Service is not covered with this procedure.	CO
5065	SUTURING NOT ALLOWED IN COMBINATION WITH PROCEDURES BILLED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5066	PROCEDURES BILLED NOT ALLOWED IN COMBINATION WITH SUTURING	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5067	ANESTHESIA ALLOWED ONCE PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5068	PROCEDURE CODE COMBINATION CANNOT BE BILLED ON THE SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5069	DATE OF SERVICE ON ANESTHESIA CLAIM ALREADY PAID	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5070	ANESTHESIA FOR THIS DATE OF SERVICE HAS ALREADY BEEN PAID BY DMA	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5073	REVENUE CODES CANNOT BE BILLED FOR THE SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5074	REVENUE CODES NOT ALLOWED WITH DIALYSIS REVENUE CODES ON THE SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5075	REVENUE CODES NOT REIMBURSEABLE WITH DIALYSIS REVENUE CODES ON THE SAM	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5076	REVENUE CODE 841 NOT ALLOWED WITH REVENUE CODES 845 OR 849 ON SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5077	REVENUE CODE 841 NOT ALLOWED WITH REVENUE CODES 845 OR 849 SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5078	COMMUNITY MENTAL HEALTH PROCEDURE CODES CANNOT BE BILLED ON SAME DAY	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5079	CLAIM FOR THIS DOS HAS BEEN PREVIOUSLY PAID	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5080	NO PAYMENT FOR THE PROCEDURES ON THE SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5081	PROCEDURE CODES CANNOT BE BILLED FOR THE SAME DATE OF SERVICE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5082	PROCEDURE CODES NOT ALLOWED ON SAME OR OVERLAPPING DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5083	MODEL WAIVER HOME CARE SERVICES CANT BE BILLED FOR SAME OR OVERLAPPING	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5084	MODEL WAIVER HOME DAYCARE SERVICES CANNOT BE BILLED ON THE SAME OR	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5085	NURSING HOME ROOM AND BOARD CANNOT BE BILLED ON THE SAME DATE OF	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5086	GENERAL INPATIENT HOSPICE CARE CANNOT BE BILLED ON THE SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5087	SERVICE BILLED IS INCLUDED IN THE HEALTH CHECK PROGRAM - SEPARATE BILL	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5088	SERVICE BILLED IS INCLUDED IN THE HEALTH CHECK PROGRAM SEPARATE BILLI	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5089	PROCEDURE CODE 85021 CANNOT BE BILLED WITH COMPONENT CODES ON THE SAME	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5090	ONLY 1 PROCEDURE IN THE RANGE OF 85021-85031 ALLOWED PER DOS FOR THE S	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5091	MEDICAL VISITS NOT ALLOWED WITH INITIAL OR ANNUAL VISIT	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5092	MEDICAL VISITS CANNOT BE BILLED WITH INITIAL/ANNUAL VISIT	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5093	THERAPY/CHILDREN INTERVENTION SERVICES DENIED AS A DUPLICATE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5094	THERAPY/CHILDREN INTERVENTION SERVICES DUPLICATE (PAY CURRENT/VOID HIS	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5095	THERAPY/CHILDREN INTERVENTION SERVICES DUPLICATE (PAY AND REPORT)	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5097	NEONATAL INTENSIVE CARE PROCEDURE CODE ALREADY PAID	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5098	EPIDURAL PAYMENT INCLUDED WITH DELIVERY FEE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N525	These services are not covered when performed within the global period of another services.	OA
5099	PROCEDURES NOT ALLOWED FOR SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5100	SERVICE NOT ALLOWED DURING MEMBERS HOSPITAL STAY - REPORT	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5101	SERVICE NOT ALLOWED DURING MEMBERS PRTF STAY	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5102	SERVICE NOT ALLOWED DURING MEMBERS PRTF STAY IS ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5103	PROCEDURES CANNOT BE BILLED FOR THE SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5105	ONLY ONE HOSPITAL ADMIT/VISIT/SERVICE ALLOWED PER DOS	119	Benefit maximum for this time period or occurrence has been reached.	N20	Service not payable with other service rendered on the same date.	CO
5106	HISTORY AND EXAM OF NORMAL NEWBORN NOT ALLOWED SAME DOS AS NICU INITIA	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5107	ECMO, NICU, OR CCU PROCEDURES CANNOT BE BILLED TOGETHER	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5108	ANTEPARTUM CARE NOT ALLOWED SAME DOS AS ABORTION PROCEDURE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N20	Service not payable with other service rendered on the same date.	CO
5109	MULTIPLE OFFICE VISITS NOT COVERED FOR SAME DOS	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	N20	Service not payable with other service rendered on the same date.	CO
5110	COS 910 CLAIM OVERLAPS SAME DOS AS COS 070	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5111	E AND F VS P CLAIM TYPES: CLAIM TYPE P IN-PROCESS	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5112	E AND F VS P CLAIM TYPES: CLAIM TYPE E IN-PROCESS	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5113	PROCEDURE INCLUDED IN ANOTHER PROCEDURE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5114	PROCEDURE CANNOT BE BILLED IN COMBINATION WITH 93510	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N59	Please refer to your provider manual for additional program and provider information.	OA
5115	SERVICE NOT ALLOWED DURING MEMBERS HOSPITAL STAY	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5116	IDENTICAL BILATERAL/UNILATERAL SURGICAL PROCEDURES CANT BE BILLED FOR	231	Mutually exclusive procedures cannot be done in the same day/setting.	N20	Service not payable with other service rendered on the same date.	CO
5117	SERVICE FOR MEMBER HAS BEEN PAID TO ANOTHER PROVIDER	18	Duplicate claim/service.	N472	Payment for this service has been issued to another provider.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5118	DUPLICATE OF A PREVIOUSLY PAID SERVICE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5119	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID SERVICE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5120	SERVICE IS AN EXACT DUPLICATE OF A PREVIOUSLY PAID SERVICE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5121	SERVICE IS A POSSIBLE DUPLICATE OF A PREVIOUSLY PAID SERVICE	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5122	EXACT DUPLICATE OF A PREVIOUSLY PAID TRANSPORTATION SERVICE	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5123	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID TRANSPORTATION SERVICE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5124	EXACT DUPLICATE OF A PREVIOUSLY PAID RHC SERVICE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5125	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID RHC SERVICE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5126	EXACT DUPLICATE OF A PREVIOUSLY PAID FREESTANDING RHC SERVICE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5127	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID FREESTANDING RHC SERVICE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5128	EXACT DUPLICATE OF A SERVICE THAT HAS ALREADY BEEN PAID	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5129	POSSIBLE DUPLICATE OF A SERVICE THAT HAS ALREADY BEEN PAID	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5130	EXTRA-CAPSULAR BILLED FOR SAME DOS AS INTRA-CAPSULAR PROCEDURE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5131	OFFICE VISIT AND REFRACTIVE EXAM NOT COVERED ON SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5132	SEDIMENTATION RATE LIMITED TO CERTAIN DIAGNOSIS CODES	11	The diagnosis is inconsistent with the procedure.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
5133	VISUAL FIELD EXAM LIMITED TO CERTAIN DIAGNOSIS CODES	11	The diagnosis is inconsistent with the procedure.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
5134	PART B CROSSOVER CLAIM IS A DUPLICATE OF PREVIOUSLY PAID STRAIGHT MEDI	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5135	PART B CROSSOVER CLAIM IS A POSSIBLE DUPLICATE OF A PREVIOUSLY PAID	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5136	PART B CROSSOVER CLAIM IS A POSSIBLE DUPLICATE OF A PREVIOUSLY PAID	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5137	MEDICAID CLAIM IS A POSSIBLE DUPLICATE OF A PREVIOUSLY PAID MEDICARE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5138	EXACT DUPLICATE OF A PREVIOUSLY PAID SERVICE	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5139	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID SERVICE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5140	EXACT DUPLICATE OF A PREVIOUSLY PAID SWING BED SERVICE	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5141	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID SWING BED SERVICE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5142	EXACT DUPLICATE OF A PREVIOUSLY PAID HOSPICE SERVICE	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5143	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID HOSPICE SERVICE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5144	EXACT DUPLICATE OF A PREVIOUSLY PAID LTC SERVICE	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5145	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID LTC SERVICE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5146	EXACT DUPLICATE INPATIENT CLAIM ALREADY PAID	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5147	POSSIBLE DUPLICATE OF A PAID INPATIENT CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5148	PART A CROSSOVER CLAIM IS A DUPLICATE OF A PREVIOUSLY PAID STRAIGHT	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5149	PART A CROSSOVER CLAIM IS A POSSIBLE DUPLICATE OF A PREVIOUSLY PAID	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5150	MEDICAID CLAIM IS A DUPLICATE OF A PREVIOUSLY PAID MEDICARE CROSSOVER	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5151	MEDICAID CLAIM IS A POSSIBLE DUPLICATE OF A PREVIOUSLY PAID MEDICARE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5152	PART C CROSSOVER CLAIM IS A DUPLICATE OF A PREVIOUSLY PAID MEDICAID	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5153	PART C CROSSOVER CLAIM IS A POSSIBLE DUPLICATE OF A PREVIOUSLY PAID	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5154	THIS MEDICAID CLAIM IS A DUPLICATE OF A PREVIOUSLY PAID TYPE-C MEDICA	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5155	THIS MEDICAID CLAIM IS A POSSIBLE DUPLICATE OF A PREVIOUSLY PAID	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5156	THIS AMBULATORY SURGICAL CENTER MEDICARE CROSSOVER CLAIM IS A DUPLIC	119	Benefit maximum for this time period or occurrence has been reached.	MA109	Claim processed in accordance with ambulatory surgical guidelines.	CO
5157	THIS ASC MEDICARE CROSSOVER CLAIM IS A POSSIBLE DUPLICATE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5158	THIS MEDICARE CROSSOVER CLAIM IS A DUPLICATE OF A PREVIOUSLY PAID MEDI	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5159	THIS MEDICARE CROSSOVER CLAIM IS A POSSIBLE DUPLICATE OF A PREVIOUSLY	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5160	GAPP MODEL WAIVER DAY CARE CONFLICT W/ CIS	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5161	CIS W/GAPP MODEL WAIVER DAY CARE CONFLICT	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5162	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5163	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5164	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5165	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5166	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5167	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5168	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5169	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5170	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5171	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5172	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5173	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5174	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5175	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5176	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5177	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5178	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5179	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5180	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5181	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5182	PROCEDURE CODE COMBINATION NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5183	CLAIM IS AN EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5184	CLAIM IS A POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5185	EXACT DUPLICATE OF A CLAIM IN HISTORY	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5186	POSSIBLE DUPLICATE OF A PAID CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5187	PAYMENT INCLUDED IN ALL-INCLUSIVE ENCOUNTER PROCEDURE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5189	HISTORY CLAIM VOID WITH TOB 112 OR 113 WHEN THE CURRENT CLAIM TYPE OF	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
5191	PROCEDURES 92601 AND 92602 CANNOT BE BILLED ON THE SAME DATE OF SERVIC	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5193	NEONATAL, EMERGENCY, CRITICAL CARE, CONSULT OR VISITATION PROCEDURE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5194	CLAIM DENIED. PROVIDER MUST RESUBMIT BOTH SERVICES ON THE SAME CLAIM	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N377	Payment adjusted based on a processed replacement claim.	CO
5195	CLAIM DENIED. PROVIDER MUST RESUBMIT CLAIM INCLUDING	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N377	Payment adjusted based on a processed replacement claim.	CO
5196	REVENUE CODES NOT REIMBURSEABLE WITH DIALYSIS REVENUE CODES ON THE SAM	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5197	REVENUE CODE 841 NOT ALLOWED WITH REVENUE CODES 845 OR 849 SAME DOS.	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5198	SERVICE BILLED IS INCLUDED IN THE HEALTH CHECK PROGRAM SEPARATE BILLI	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5199	PSYCHIATRIC SERVICE NOT COVERED ON THE SAME DAY AS HOSPITAL ADMIT/VIS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N20	Service not payable with other service rendered on the same date.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5200	INTERPERIODIC VISION/HEARING NON-COV SAME DOS AS COMPLETE SCREENING.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
5201	OFFICE E/M CODES AND/OR U/A ARE INCLUDED IN THE GLOBAL OBSTETRICAL FEE.	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N59	Please refer to your provider manual for additional program and provider information.	OA
5202	A PAID UNILATERAL AND BILATERAL PROCEDURE ON THE SAME CLAIM, BOTH NOT ALLOWED.	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M50	Missing/incomplete/invalid revenue code(s).	CO
5203	MEDICAL VISITS CANNOT BE BILLED WITH INITIAL/ANNUAL VISIT. REBILL APPROPRIATE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5204	GENERAL INPATIENT HOSPICE CARE CANNOT BE BILLED ON THE SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5205	RESTORATION NON-COVERED FOR PREVIOUSLY EXTRACTED TOOTH, REBILL PROPER	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.	CO
5206	PROCEDURES CANNOT BE BILLED FOR THE SAME DOS, REBILL PROPER PROCEDURE.	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5207	PROCEDURES NOT ALLOWED WITH SEDATIVE FILLING, REBILL PROPER PROCEDURE.	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N431	Service is not covered with this procedure.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5208	PROCEDURES BILLED NOT ALLOWED IN COMBINATION WITH SUTURING	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5209	PROCEDURE 96110 NOT ALLOWED BETWEEN AGE 10-17 MONTHS IF PROVIDED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5210	PROCEDURE 96110 NOT ALLOWED BETWEEN AGE 19-29 MONTHS IF PROVIDED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5211	PROCEDURE 96110 NOT ALLOWED BETWEEN AGE 31-35 MONTHS IF PROVIDED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5212	PROCEDURE T1016 NOT ALLOWED WITH T2022 SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5213	PROCEDURE H2023 NOT ALLOWED WITH H2025 SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5214	PROCEDURE T2038 NOT ALLOWED WITH T2038/UC SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5215	PROCEDURE H0038/HA NOT ALLOWED WITH H0038/UC SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5216	PROCEDURE T2028 NOT ALLOWED WITH T2028/UC SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5217	PROCEDURE T2003 NOT ALLOWED WITH T2003/UC SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5218	PROC H0038 UC, HR/UC OR HS/UC NOT ALLOWED WITH H0038 NON-UC, HR/UC	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5219	PROCEDURES S5150 OR S5151 NOT ALLOWED SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5220	PROCEDURES H2019/UC AND H2019 (NON-UC) NOT ALLOWED SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5221	DRUG CODE NOT ALLOWED SAME DAY	236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement	CO
5222	DRUG CODE NOT ALLOWED SAME DAY	236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5223	DRUG CODE NOT ALLOWED OVERLAPPING DOS	236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement	CO
5224	DRUG CODE NOT ALLOWED OVERLAPPING DOS	236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement	CO
5300	ENCOUNTER INPATIENT-EXACT DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5301	ENCOUNTER OUTPATIENT-EXACT DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5302	ENCOUNTER PROFESSIONAL-EXACT DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5303	ENCOUNTER DENTAL-EXACT DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5304	ENCOUNTER PHARMACY-EXACT DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5305	EXACT DUPLICATE OF A PREVIOUSLY PAID NET CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5360	M0064 IS LIMITED TO ONE EVERY 14 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
5415	PROCEDURE NOT ALLOWED WITH S5101	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5473	PROCEDURE CODE COMBINATION NOT ALLOWED	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5474	PROCEDURE NOT ALLOWED WITH HEPATITIS PANEL BILLING 80059 OR 80074	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5475	PROCEDURE NOT ALLOWED WITH HEPATITIS PANEL BILLING 80059 OR 80074	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5476	PROCEDURE NOT ALLOWED WITH HEPATITIS PANEL BILLING 80059 OR 80074	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5477	PROCEDURE NOT ALLOWED WITH HEPATITIS PANEL BILLING 80059 OR 80074	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5500	PROCEDURE CODES NOT ALLOWED IN SAME CALENDAR MONTH	133	The disposition of this claim/service is pending further review.	N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	PI
5501	PROCEDURES NOT REIMBURSABLE FOR SAME MONTH OF SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5502	REGULAR, SELF-DIRECT, AND CO-EMPLOYER COMMUNITY ACCESS GROUP SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5503	REGULAR, SELF-DIRECT, AND CO-EMPLOYER COMMUNITY ACCESS INDIVIDUAL SERV	119	Benefit maximum for this time period or occurrence has been reached.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5504	REGULAR, SELF-DIRECT, AND CO-EMPLOYER SUPPORT EMPLOYMENT GROUP SERVIC	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
5505	REGULAR, SELF-DIRECT AND CO-EMPLOYER SUPPORT EMPLOYMENT INDIVIDUAL	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5507	REGULAR, SELF-DIRECT, AND CO-EMPLOYER COMMUNITY LIVING SUPPORT SERVICE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5508	REGULAR, SELF-DIRECT, AND CO-EMPLOYER COMMUNITY LIVING SUPPORT DAILY	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5512	RURAL HEALTH ENCOUNTER LIMIT. CANNOT BILL MULTIPLE RURAL HEALTH ENCOUN	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5514	FQHC ENCOUNTER LIMIT - CANNOT BILL MULTIPLE FQHC ENCOUNTERS FOR THE SA	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5515	REGULAR, SELF-DIRECT, AND CO-EMPLOYER RESPITE SERVICES NOT ALLOWED IN	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5516	REGULAR, SELF-DIRECT, AND CO-EMPLOYER RESPITE OVERNIGHT SERVICES NOT A	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5517	NATURAL SUPPORT TRAINING SERVICE NOT ALLOWED WITH SELF DIRECTED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
5520	REGULAR SPECIALIZED MEDICAL EQUIPMENT NOT ALLOWED WITH SELF DIRECTED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M3	Equipment is the same or similar to equipment already being used.	OA
5521	REGULAR SPECIALIZED MEDICAL SUPPLIES NOT ALLOWED WITH SELF DIRECTED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
5522	REGULAR VEHICLE ADAPTATIONS NOT ALLOWED WITH SELF DIRECTED VEHICLE ADA	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
5523	ENVIRONMENTAL ACCESSIBILITY ADAPTATION NOT ALLOWED WITH SELF DIRECTED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5524	REGULAR OT EVALUATION AND SELF DIRECTED OT EVALUATION NOT ALLOWED SAME	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N20	Service not payable with other service rendered on the same date.	CO
5525	REGULAR OT THERAPEUTIC ACTIVITIES NOT ALLOWED WITH SELF DIRECTED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5526	REGULAR OT SENSORY INTEGRATIVE TECHNIQUES NOT ALLOWED WITH SELF DIRECT	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5527	REGULAR PT EVALUATION NOT ALLOWED WITH SELF DIRECTED PT EVALUATION SAM	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5528	REGULAR PT THERAPEUTIC PROCEDURES NOT ALLOWED WITH SELF DIRECTED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5529	REGULAR SPEECH LANGUAGE EVALUATION NOT ALLOWED WITH SELF DIRECTED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5530	REGULAR SPEECH LANGUAGE THERAPY NOT ALLOWED WITH SELF DIRECTED SPEECH	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5531	REGULAR SPEECH GENERATING DEVICE THERAPY NOT ALLOWED WITH SELF DIRECTE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5532	REGULAR BEHAVIORAL SUPPORT CONSULTATION NOT ALLOWED WITH SELF DIRECTED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5533	REGULAR, SELF-DIRECT, CO-EMPLOYER TRANSPORTATION ENCOUNTER NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5534	REGULAR AND SELF-DIRECT TRANSPORTATION COMMERCIAL CARRIER NOT ALLOWED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5535	PROCEDURE CODES CANNOT BE BILLED IN THE SAME CALENDAR MONTH	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5536	NSES RESIDENTIAL TRAINING, PERSONAL SUPPORT SERVICES OR RESPITE SERVIC	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5537	PERSONAL SUPPORT SERVICES CANNOT BE BILLED IN THE SAME CALENDAR MONTH	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
5544	CASE MANAGEMENT SERVICE FOR THIS CALENDAR MONTH HAS ALREADY BEEN PAID	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
5545	PROCEDURE CODES MAY NOT BE BILLED WITHIN 14 DAYS OF EACH OTHER	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5546	DIALYSIS PROCEDURES NOT ALLOWED IN THE SAME MONTH	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N59	Please refer to your provider manual for additional program and provider information.	OA
5547	OFFICE E/M CODES AND/OR U/A ARE INCLUDED IN THE GLOBAL OBSTETRICAL FEE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N525	These services are not covered when performed within the global period of another services.	OA
5548	OFFICE E/M CODES AND/OR U/A ARE INCLUDED IN THE GLOBAL OBSTETRICAL FEE	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N59	Please refer to your provider manual for additional program and provider information.	OA
5550	FETAL MONITORING PROCEDURES BILLED WITHIN 280 DAYS OF DELIVERY PROCEDU	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
5551	SERVICE BILLED INCLUDED IN GLOBAL OBSTETRICAL FEES	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N525	These services are not covered when performed within the global period of another services.	OA
5552	GLOBAL AND ITEMIZED FEES CANNOT BE BILLED FOR THE SAME PRENANCY	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
5553	ITEMIZED CODES BILLED WITH GLOBAL OR DELIVERY CODES FOR THE SAME PREGN	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N525	These services are not covered when performed within the global period of another services.	OA
5554	GLOBAL FEE HAS BEEN PAID FOR THIS PREGNANCY	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N525	These services are not covered when performed within the global period of another services.	OA
5555	HEARING AID NOT REPLACEABLE WITHIN 3 YEARS	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5556	BRACHYTHERAPY INCLUDES HOSPITAL ADMISSION AND VISITS	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5557	NURSING SERVICES NOT ALLOWED ON SAME OR OVERLAPPING DATES AS OTHER NUR	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5558	NURSING SERVICE AND MEDICALLY FRAGILE DAYCARE SERVICE CONFLICT	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5559	NURSING SERVICES NOT ALLOWED ON SAME OR OVERLAPPING DATES AS OTHER NUR	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5560	GAPP MODEL WAIVER DAY CARE SVC CONFLICTS WITH HOME HEALTH PROCEDURE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5561	HOME HEALTH CONFLICT W/ GAPP MODEL WAIVER DAY CARE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5562	MULTIPLE SURGERY WITHIN 2 DAYS - PODIATRY, SUSPENDED FOR REVIEW	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
5563	PROCEDURE 99601 MUST BE ON CURRENT CLAIM OR PAID HISTORY FOR SAME DATE	B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N122	Add-on code cannot be billed by itself.	OA
5564	PROCEDURES T2022 AND T2025 NOT ALLOWED SAME CALENDAR MONTH	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5565	PROCEDURES 90471, 90473 OR 90460 NOT ALLOWED SAME DAY	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5566	PROCEDURES NOT ALLOWED SAME DAY AS 90460, 90473 OR 90474	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5600	PROCEDURE 92586 CANNOT BE BILLED WITH 92585 ON THE SAME DOS	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5601	PROCEDURE 92587 ALLOWED ONLY ONCE PER DAY AND CANNOT BE BILLED IN COMB	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5602	Y0186, Y0187, Y0188, Y0189, T2023/U1, T2023/U2, G9001/HT NOT ALLO	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5603	PROCEDURE CODES CANNOT BE BILLED ON SAME DAY	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5604	PHYSICAL THERAPY OR SPEECH THERAPY IS NOT ALLOWED IN THE SAME CALENDAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
5605	MEDICAL DAY CARE CONFLICTS WITH PHYSICAL THERAPY OR SPEECH THERAPY IN	119	Benefit maximum for this time period or occurrence has been reached.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5606	OFFICE VISIT NOT ALLOWED ON THE SAME DOS AS AN ABNORMAL HEALTH CHECK	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N20	Service not payable with other service rendered on the same date.	CO
5607	SUSPECT DUPLICATE OF A PROFESSIONAL CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5608	SERVICE IS A POSSIBLE DUPLICATE OF A PREVIOUS MEDICAL SUPPLY CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5609	SERVICE NOT ALLOWED SAME DOS AS A COMPREHENSIVE HEALTH CHECK SCREEN	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5610	EXACT DUPLICATE OF A PREVIOUSLY PAID SERVICE	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5611	EXACT DUPLICATE OF A PROFESSIONAL CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5617	EXACT DUPLICATE OF A PROFESSIONAL CLAIM VS DIALYSIS TECHNICAL CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5619	EXACT DUPLICATE OF A MEDICAL SUPPLY CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5621	PROFESSIONAL-POSSIBLE DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5626	POSSIBLE DUPLICATE OF A PROFESSIONAL CLAIM VS DIALYSIS TECHNICAL CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5628	PROFESSIONAL-POSSIBLE CONFLICT WITH ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5631	DUPLICATE UNILATERAL/BILATERAL PROCEDURE	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5632	A PREVIOUSLY-PAID UNILATERAL PROCEDURE WILL BE ADJUSTED AND DENIED AS	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M50	Missing/incomplete/invalid revenue code(s).	CO
5633	A COS 790 CLAIM FOR PHYSICAL/SPEECH/OCCUPATIONAL THERAPY OR AN AUDIOLO	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5634	A COS 840/960 CLAIM FOR PHYSICAL/SPEECH/OCCUPATIONAL THERAPY OR AN AUD	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5635	CRITICAL CARE MAY BE PAID TO MULTIPLE PROVIDERS WITH DIFFERENT SPECIAL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
5638	PROCEDURE NOT ALLOWED ON SAME DOS AS AN ABNORMAL HEALTH CHECK EXAM	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5639	OV CANNOT BE BILLED ON THE SAME DAY AS HC PERIODIC SCREENING	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N377	Payment adjusted based on a processed replacement claim.	CO
5640	CROSSOVER CLAIM IS A POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5641	CLAIM IS A DUPLICATE OF A PAID HISTORY OR CURRENT APPROVED CROSSOVER	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5642	STERILIZATION/HYSTERECTOMY - PEND FOR REVIEW	133	The disposition of this claim/service is pending further review.	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	PI
5643	ONLY ONE COMPLETE SCREENING ALLOWED PER SCREENING SEQUENCE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
5644	SUSPECT DUPLICATE HOME HEALTH VS COMMUNITY CARE - SUSPEND	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5645	INPATIENT CROSSOVER-EXACT DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5646	PROFESSIONAL CROSSOVER-EXACT DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5647	OUTPATIENT CROSSOVER-EXACT DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5648	EXACT DUPLICATE OF A FQHC OR RCH CLAIM VS PROFESSIONAL CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5650	EXACT DUPLICATE OF AN OUTPATIENT CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5651	EXACT DUPLICATE OF AN OUTPATIENT CLAIM VS HEALTH CHECK CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5652	EXACT DUPLICATE OF A HOME HEALTH CLAIM VS WAIVER CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5653	INPATIENT CROSSOVER-POSSIBLE DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5654	PROFESSIONAL CROSSOVER-POSSIBLE DUPLICATE OF ANOTHER CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5655	SUSPECT DUPLICATE OF AN OUTPATIENT CROSSOVER CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5656	POSSIBLE DUPLICATE OF A DIALYSIS PROFESSIONAL VS TECHNICAL CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5657	POSSIBLE DUPLICATE OF A PAID OUTPATIENT CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5658	POSSIBLE DUPLICATE OF AN OUTPATIENT CLAIM VS A HEALTH CHECK CLAIM	18	Duplicate claim/service.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5660	HOME HEALTH-POSSIBLE DUPLICATE OF A WAIVER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5661	INPATIENT CROSSOVER-POSSIBLE CONFLICT WITH ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5662	PROFESSIONAL CROSSOVER-POSSIBLE CONFLICT WITH ANOTHER CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5663	POSSIBLE CONFLICT BETWEEN CROSSOVER CLAIMS	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5665	TRANSFER LOGIC - REPROCESS HISTORY CLAIM	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
5666	MODEL WAIVER HOME CARE SERVICES CANNOT BE BILLED ON THE SAME OR OVERLA	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5667	INPATIENT CLAIM CONFLICTS WITH A PREVIOUSLY PAID NURSING HOME CLAIM	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5668	NURSING HOME CLAIM CONFLICTS WITH A PREVIOUSLY PAID INPATIENT CLAIM	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5669	NEWBORN SCREENING LIMIT EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
5672	POSSIBLE DUPLICATE OF ANOTHER CLAIM ON FILE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5800	ANESTHESIA PROCEDURE 09153 IS NOT PAYABLE WITHOUT 09152	B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N390	This service cannot be billed separately.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5801	LABOR PROCEDURE CANNOT BE BILLED W/O REPAIR ON SAME DOS	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	N390	This service cannot be billed separately.	CO
5802	PURCHASE PROCEDURE CODE REQUIRED FOR ITEM BEING MODIFIED OR REPAIRED	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	N59	Please refer to your provider manual for additional program and provider information.	CO
5803	TRANSPORTATION PROCEDURE Y0407 NOT ALLOWED W/O PROCEDURE Y0414, Y0408	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	N390	This service cannot be billed separately.	CO
5804	ESCORT PROC Y0412 ONLY ALLOWED WITH Y0400 ��� Y0407, Y0415, Y0416 OR Y04	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M22	Missing/incomplete/invalid number of miles traveled.	CO
5805	LABOR PROCEDURE NOT ALLOWED W/O REPAIR OR MODIFICATION ON SAME DOS	B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	OA
5806	AN ACCESSORY PROCEDURE CODE REQUIRES E0570NU OR E0600NU WITH $0.00 ON	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	N390	This service cannot be billed separately.	CO
5807	PURCHASE PROCEDURE CODE REQUIRED FOR ITEM BEING REPAIRED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5808	PURCHASE PROCEDURE REQUIRED FOR ITEM BEING REPAIRED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
5809	COMPREHENSIVE VISITS MUST BE PAID BEFORE ANY OTHER PROCEDURE CAN BE	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	N390	This service cannot be billed separately.	CO
5810	FOLLOW-UP CARE NOT COVERED W/O PAID SURGERY CODE OR SURGEON HAS BEEN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	CO
5811	ESCORT NOT ALLOWED IF TRANSPORTATION IS NOT PAID	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N356	This service is not covered when performed with, or subsequent to, a non-covered service.	CO
5812	OPTICAL DEVICE CODES MUST BE PAID BEFORE DISPENSING FEE CAN BE PAID	B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N59	Please refer to your provider manual for additional program and provider information.	OA
5813	DENTAL PROCEDURES COVERED FOR PREGNANT MEMBERS ONLY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
5814	COMPREHENSIVE SERVICE NOT DONE PRIOR TO FOLLOW- UP	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
5815	ORAL RISPERDAL DRUG MUST BE PAID PRIOR TO J2794	B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N59	Please refer to your provider manual for additional program and provider information.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5816	EPIDURAL PROCEDURES REQUIRE PRE- CERTIFICATION WHEN SUBMITTED WITHOUT	197	Payment adjusted for absence of precertification/ authorization.	M62	Missing/incomplete/invalid treatment authorization code.	CO
5817	PRIOR REQUIRED DRUG FOR J9035 IS NOT IN PATIENT HISTORY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
5818	S4502 ALLOWED WITH Y0186, Y0187,Y0188 OR Y0189 ON THE SAME DOS IF BILL	B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	M66	Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate li	OA
5819	INPATIENT INTERIM CLAIM REPLACEMENT NOT VALID	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
5821	FINANCIAL MANAGEMENT SERVICES CANNOT BE BILLED PRIOR TO SELF DIRECTED	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
5822	DENTAL PROCEDURES NOT COVERED IF EVIDENCE OF NON-PREGNANCY	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
5823	DENTAL PROCEDURES SHOULD BE REPROCESSED, DELIVERY CLAIM BILLED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N30	Patient ineligible for this service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5824	ADD-ON PROCEDURE NOT ALLOWED W/O PAID PRIMARY CODE	B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N122	Add-on code cannot be billed by itself.	OA
5825	INPATIENT PERSONAL SUPPORT SERVICES CONFLICT	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5826	PERINATAL CASE MANAGEMENT SERVICE MUST BE WITHIN REQUIRED TIMEFRAME	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	CO
5827	PREGNANCY RELATED SERVICE MUST BE WITHIN REQUIRED TIME PERIOD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	CO
5828	NO DATE OF DELIVERY CLAIM HAS BEEN FOUND RELATED TO THE BILLED PRS/PCM	B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N59	Please refer to your provider manual for additional program and provider information.	OA
5830	PROCEDURE NOT ALLOWED WITH CASE MANAGEMENT	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N431	Service is not covered with this procedure.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5831	PROCEDURE CANNOT BE BILLED INDEPENDENTLY	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	N390	This service cannot be billed separately.	CO
5832	92526HA MAY NOT BE BILLED WITH 97530HA GP /97530HA GO OR 97532HA BY TH	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5833	97533HA GN /97533HA GO MAY NOT BE BILLED WITH 97004HA OR 97530HA GP 97	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5834	97532HA MAY NOT BE BILLED WITH 97004HA, 97530HA GP/97530HA GO OR 92526	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5835	92551 OR 92506HA MAY NOT BE BILLED WITH 92526HA, 92610HA OR 92611 BY T	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5836	92507TM GN/92507TM UC MAY NOT BE BILLED WITH 97532TM, 97530TM GP/97530	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5837	92526TM MAY NOT BE BILLED WITH 97530TM GP /97530TM GO OR 97532TM BY TH	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5838	97533TM GN /97533TM GO MAY NOT BE BILLED WITH 97004TM OR 97530TM GP 97	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5839	97532TM MAY NOT BE BILLED WITH 97004TM, 97530TM GP/97530TM GO OR 92526	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5840	92551 OR 92506TM MAY NOT BE BILLED WITH 92526TM, 92610TM OR 92611 BY T	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5841	92507HA GN/92507HA UC MAY NOT BE BILLED WITH 97532HA, 97530HA GP/97530	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N20	Service not payable with other service rendered on the same date.	OA
5842	PROCEDURE PAYMENT DEPENDS ON A BASE CODE PAID IN HISTORY	B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N122	Add-on code cannot be billed by itself.	OA
5844	PROCEDURES 99211 AND 99212 W/MODIFIER EP-25 MUST BE BILLED ON SAME CLA	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
5845	D8670 NOT ALLOWED WITHOUT PAID D8080	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N59	Please refer to your provider manual for additional program and provider information.	CO
5846	PROCEDURE 96110 NOT ALLOWED WITHOUT HEALTH CHECK VISIT ON SAME CLAIM,	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5847	PROCEDURES 90472 OR 90474 BILLED WITHOUT PRIMARY CODE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N59	Please refer to your provider manual for additional program and provider information.	CO
5848	MODIFIER 25 NOT ALLOWED WITHOUT VACCINE ADMIN CODE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N59	Please refer to your provider manual for additional program and provider information.	CO
5850	TOB 110 WITH NO HISTORY TOB 110	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA30	Missing/incomplete/invalid type of bill.	CO
5851	TOB 110 WITH NO HISTORY TOB 110	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA30	Missing/incomplete/invalid type of bill.	CO
5852	FLU VACCINE NOT ALLOWED WITHOUT ADMIN CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5853	ADMIN CODE NOT ALLOWED WITHOUT FLU VACCINE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
5920	THIS PROCEDURE WAS UNBUNDLED PER DCH POLICY	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N59	Please refer to your provider manual for additional program and provider information.	CO
5923	THIS PROCEDURE WAS UNBUNDLED FROM A COMPOSITE PROCEDURE PER DCH POLICY	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N59	Please refer to your provider manual for additional program and provider information.	CO
5924	THIS PROC IS CONSIDERED MUTUALLY EXLUSIVE WITH ANOTHER PROC BILLED ON	231	Mutually exclusive procedures cannot be done in the same day/setting.	N524	Based on policy this payment constitutes payment in full.	CO
5925	THIS PROC IS CONSIDERED MUTUALLY EXLUSIVE WITH ANOTHER PROC BILLED ON	231	Mutually exclusive procedures cannot be done in the same day/setting.	N524	Based on policy this payment constitutes payment in full.	CO
5926	THIS PROC IS CONSIDERED INCIDENTAL TO ANOTHER PROC BILLED ON THE SAME	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N19	Procedure code incidental to primary procedure.	OA
5927	THIS PROC IS CONSIDERED INCIDENTAL TO ANOTHER PROC BILLED ON A HISTORY	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N19	Procedure code incidental to primary procedure.	OA
5928	PAYMENT DENIED FOR NCCI - SERVICE NOT PAYABLE WITH ANOTHER SERVICE ON	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N19	Procedure code incidental to primary procedure.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
5929	PAYMENT DENIED FOR UNITS OF SERVICE EXCEEDING NCCI MEDICALLY UNLIKELY EDIT	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	N19	Procedure code incidental to primary procedure.	OA
5932	SERVICE ALLOWED IN INPATIENT SETTING ONLY	5	The procedure code/bill type is inconsistent with the place of service.	N428	Service/procedure not covered when performed in this place of service.	CO
5933	BUNDLING/REBUNDLING HISTORY ADJUSTMENT - INFORMATIONAL	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO
5934	SERVICE ALLOWED IN INPATIENT SETTING ONLY	5	The procedure code/bill type is inconsistent with the place of service.	N428	Service/procedure not covered when performed in this place of service.	CO
5935	SEPARATE SERVICES REBUNDLED AS THEY ARE CONSIDERED COMPONENTS OF THE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CO
5938	BILATERAL PROCEDURE DUPLICATE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5939	UNI/BILATERAL PROCEDURE DUPLICATE	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
5940	Y4240, Y4260, T2002, T2002TN, T2003 OR T2003TN MUST BE BILLED FOR SAME	B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N59	Please refer to your provider manual for additional program and provider information.	OA
6039	PROCEDURES APPLICABLE TO THIS EXCEPTION ARE LIMITED TO THREE IN A LIFE	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6040	SERVICE LIMITED TO ONE IN 280 DAYS. THIS LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6042	MALOCCLUSION ADJUSTMENT LIMIT 24 PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6043	INITIAL CONSULTATIONS ARE LIMITED TO ONE PER MEMBER PER PROVIDER	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6044	CRUTCHES ARE LIMITED TO ONE PER YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6046	THIS PROCEDURE CODE IS LIMITED TO TWO UNITS PER CLIENT PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
6047	PROCEDURE LIMITED TO 4 TIMES PER MONTH PER MEMBER WHEN PERFORMED IN A	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
6052	VISIT LIMITATION EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6054	TREATMENT PLAN CANNOT NOT EXCEED ONE PER STATE FISCAL YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
6056	MAX ALLOWED 20 UNITS PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6057	56 MAX UNITS OF SERVICE PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6058	DAY TREATMENT NOT TO EXCEED 192 UNITS/FISCAL YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6059	LEAVE DAYS EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6060	UNITS OF SERVICE EXCEED ALLOWED FOR THIS REVENUE CODE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6086	NEW PATIENT VISIT HAS BEEN PREVIOUSLY PAID	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
6100	PROCEDURE CODE EXCEEDS 4 UNITS PER CALENDAR MONTH WITHOUT PA SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6101	PROCEDURE CODE EXCEEDS 6 PER CALENDAR MONTH SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6102	PROCEDURE CODE EXCEEDS 20 UNITS PER CALENDAR MONTH WITHOUT PA SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6103	PROCEDURE CODE EXCEEDS 360 HOURS PER CALENDAR YEAR SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6104	PROCEDURE CODE EXCEEDS DAILY LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6105	PROCEDURE CODES EXCEEDS MAXIMUM AMOUNT PER CALENDAR YEAR W/O PA	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6113	THIS PROCEDURE IS LIMITED TO FOUR IN ONE WEEK. LIMIT HAS BEEN MET	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6114	TOTAL AMOUNT PAID EXCEEDS STATE FISCAL YEAR LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
6115	THIS PROCEDURE IS LIMITED TO TWO TIMES IN A LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6116	LIMITED TO 52 PER FISCAL YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6118	COMMUNITY LIVING SUPPORT SERVICES MAXIMUM AMOUNT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6119	COMMUNITY LIVING SUPPORT MAXIMUM AMOUNT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6120	TOTAL PAID AMT EXCEEDS YEARLY LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6121	COMMUNITY ACCESS INDIVIDUAL SERVICES MAXIMUM AMOUNT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6122	PREVOCATIONAL SERVICES MAXIMUM AMOUNT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6123	SUPPORTED EMPLOYMENT INDIVIDUAL SERVICES MAXIMUM AMOUNT HAS BEEN REACH	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6125	RESPITE SERVICES MAXIMUM AMOUNT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6126	NATURAL SUPPORT TRAINING SERVICE MAXIMUM AMOUNT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6127	INDIVIDUAL DIRECTED GOODS AND SERVICES MAXIMUM AMOUNT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6128	ADULT THERAPIES MAXIMUM AMOUNT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6129	ADULT OT EVALUATION MAXIMUM AMOUNT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6130	ADULT PT EVALUATION MAXIMUM AMOUNT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6131	ADULT SPEECH LANGUAGE EVALUATION MAXIMUM AMOUNT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6132	BEHAVIORAL SUPPORT CONSULTATION MAXIMUM AMOUNT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6133	TRANSPORTATION ENCOUNTER MAXIMUM AMOUNT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6135	TOTAL AMOUNT PAID EXCEEDS MEMBER YEARLY SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6136	TOTAL AMOUNT PAID EXCEEDS MEMBER MONTHLY SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6137	PROCEDURE CODE UNITS EXCEED YEARLY LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6138	PROCEDURE CODE EXCEEDS 1 UNIT PER MONTH SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6139	PROCEDURE CODE EXCEEDS $10,000 MEMBER STATE FISCAL YEAR SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6140	PROCEDURE CODE EXCEEDS 6 UNITS PER LIFETIME SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6141	PROCEDURE CODE EXCEEDS 1 UNIT PER MONTH SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6142	PROCEDURE CODE EXCEEDS 960 UNITS PER STATE FISCAL YEAR SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6143	PROCEDURE CODE EXCEEDS 1 UNIT PER MONTH SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6144	PROCEDURE CODE EXCEEDS 31 UNITS PER MONTH SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6145	TOTAL PAID AMOUNT EXCEEDS $10,400.00 PER LIFETIME SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6146	PROCEDURE CODE EXCEEDS REIMBURSED ONCE PER WEEK SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6147	TOTAL PAID AMOUNT EXCEEDS $3,120.00 PER LIFETIME SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6148	TOTAL PAID AMOUNT EXCEEDS $3,120.00 PER LIFETIME SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6149	TOTAL PAID AMOUNT EXCEEDS LIFETIME SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6150	PROCEDURE CODE EXCEEDS 1 UNIT PER LIFETIME OF SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6151	PROCEDURE CODE EXCEEDS UNITS EXCEED YEARLY LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6152	PROCEDURE CODE EXCEEDS 312 HOURS PER FISCAL YEAR SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6153	PROCEDURE CODE EXCEEDS 1 UNIT PER MONTH SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6154	PROCEDURE CODE EXCEEDS 6 UNITS PER LIFETIME SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6155	PROCEDURE CODE EXCEEDS 960 UNITS PER FISCAL YEAR SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6156	PROCEDURE CODE EXCEEDS 27 UNITS PER MONTH SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6157	PROCEDURE CODE EXCEEDS 240 UNITS PER FISCAL YEAR SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6158	PROCEDURE CODE EXCEEDS 960 HOURS PER FISCAL YEAR SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6159	PROCEDURE CODE EXCEEDS 320 UNITS PER CALENDAR MONTH SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6160	HOME DELIVERED MEALS EXCEEDS 3 UNITS PER DOS SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6161	PROCEDURE CODE EXCEEDS SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6163	TOTAL AMOUNT PAID EXCEEDS STATE FISCAL YEAR LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6164	PROCEDURE HAS BEEN REIMBURSED FOR THIS MONTH OF SERVICE	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
6165	TOTAL PAID AMT EXCEEDS $20,000.00 PER STATE FISCAL YEAR SERVICE LIMIT	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N113	Only one initial visit is covered per physician, group practice or provider.	CO
6166	PROCEDURE CODE REIMBURSEABLE ONCE WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
6167	FINANCIAL MANAGEMENT PROCEDURE EXCEEDS 1 UNIT PER CALENDAR MONTH SERVI	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6168	NSES SERVICES EXCEED 200 UNITS WITHIN STATE FISCAL YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6169	PROCEDURES Y3027 AND H2011U2 LIMITED TO 8 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6170	PROCEDURE CODES Y3005 AND H0014 LIMITED TO 32 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6171	PROCEDURE CODES LIMITED TO 1 UNIT PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6172	PROCEDURE CODES LIMITED TO 1 UNIT PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6173	PROCEDURE CODE LIMITED TO 1 UNIT PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6174	PROCEDURE CODES LIMITED TO 8 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6175	PROCEDURE CODES LIMITED TO 1 UNIT PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6176	PROCEDURE CODES LIMITED TO 1 UNIT PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6177	PROCEDURE CODES LIMITED TO 32 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6178	PROCEDURE CODES LIMITED TO 24 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6179	PROCEDURE CODES LIMITED TO 96 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6180	PROCEDURE CODE EXCEEDS 16 PER DAY SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6181	PROCEDURE CODE EXCEEDS 16 UNITS PER DAY SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6182	PROCEDURE CODE EXCEEDS 60 HOURS PER CALENDAR MONTH SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6183	TOTAL AMOUNT PAID EXCEEDS MEMBER SERVICE LIMIT PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6184	PROCEDURE CODE EXCEEDS 24 UNITS SERVICE LIMIT PER DATE OF SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6185	PROCEDURE CODES Y4070, S5102 AND S5102/U1 LIMITED TO $65.00 PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6186	PROCEDURE CODES Y4020, T1030 AND T1030/U1 LIMITED TO $49.79 PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6187	PROCEDURE CODE EXCEEDS ANNUAL SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6188	PROCEDURE CODE EXCEEDS DAILY SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6189	PROCEDURE CODE EXCEEDS DAILY SERVICE LIMITS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6190	PROCEDURE CODE EXCEEDS ANNUAL SERVICE LIMITS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6191	PROCEDURE CODE EXCEEDS DAILY SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6192	PROCEDURE CODE EXCEEDS MONTHLY SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6193	PROCEDURE CODE EXCEEDS THE 14 UNIT ANNUAL SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6194	PROCEDURE CODE EXCEEDS DAILY AMOUNT SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6197	TOTAL PAID AMOUNT EXCEEDS $1,026.00 PER CALENDAR MONTH SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6198	PROCEDURE CODE EXCEEDS ONCE PER RESIDENCE SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6199	TOTAL PAID AMOUNT EXCEEDS $225.00 PER CALENDAR YEAR SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6200	PROCEDURE CODE EXCEEDS ONCE PER CALENDAR MONTH SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6201	PROCEDURE CODE EXCEEDS 2 UNITS PER DAY SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6202	PROCEDURES LIMITED TO 12 HOURS PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6203	PROCEDURE CODE EXCEEDS 12 HOURS PER CALENDAR MONTH SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6204	PROCEDURE CODE EXCEEDS 20 UNITS PER CALENDAR MONTH SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6205	PROCEDURE CODE EXCEEDS 40 UNITS PER CALENDAR MONTH SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6206	PROCEDURE CODE LIMITED TO 1 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6207	PROCEDURE CODE EXCEEDS LIFETIME SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6208	PROCEDURE CODE EXCEEDS DAILY SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6209	PROCEDURE CODE EXCEEDS ONE UNIT PER 3 CALENDAR YEARS SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6210	PROCEDURE CODE EXCEEDS ONCE PER CALENDAR YEAR SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6211	REIMBURSEMENT ALLOWED ONLY FOR THE INDICATED NUMBER OF UNITS W/O PA	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6212	REIMBURSEMENT ALLOWED ONLY FOR THE INDICATED # OF UNITS W/O PRIOR AUTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6213	REIMBURSEMENT ALLOWED ONLY FOR THE INDICATED # OF UNITS WITHOUT PA	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6214	DENTAL EXAMINATION EXCEEDS LIMIT OF 2 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6215	PROCEDURE D1203 AND D1204 ONLY ALLOWED TWICE PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6216	DENTAL FULL MOUTH RADIOGRAPH LIMITED TO ONE IN THREE CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6217	TOOTH 02 LIMITED TO ONE SEALANT PER FOUR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6218	TOOTH 03 LIMITED TO ONE SEALANT PER FOUR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6219	TOOTH 14 LIMITED TO ONE SEALANT PER FOUR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6220	TOOTH 15 LIMITED TO ONE SEALANT PER FOUR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6221	TOOTH 18 LIMITED TO ONE SEALANT PER FOUR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6222	TOOTH 19 LIMITED TO ONE SEALANT PER FOUR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6223	TOOTH 30 LIMITED TO ONE SEALANT PER FOUR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6224	TOOTH 31 LIMITED TO ONE SEALANT PER FOUR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6225	DENTAL X-RAYS EXCEED LIMIT OF $100 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6226	DENTAL PROSTHESIS (LOWER) NOT REPLACEABLE FOR 3 YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6227	DENTAL PROSTHESIS (UPPER) NOT REPLACEABLE FOR 3 YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6228	LOWER DENTURE ADJUSTMENTS LIMITED TO TWO PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6229	UPPER DENTURE ADJUSTMENT LIMITED TO TWO PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6230	PROPHYLAXIS LIMITED TO TWO PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6231	TISSUE CONDITIONING LIMITED TO TWO EACH PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6232	PROCEDURE CODE D0110 OR D0150 ALLOWED ONE PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6233	EYEGLASS FRAMES EXCEED ANNUAL SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6234	LENS EXCEEDS ANNUAL SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6235	LENS PAIR EXCEEDS ANNUAL SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6236	FITTING AND DISPENSING SERVICE EXCEEDS ANNUAL LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6237	FITTING AND DISPENSING SERVICE EXCEEDS ANNUAL LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6238	REFRACTIVE EXAM EXCEEDS ANNUAL LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6239	REFRACTIVE EXAMS EXCEED ANNUAL LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6240	POST CATARACT FOLLOW-UP EXCEEDS ONE UNIT PER 14 DAYS SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6241	PROCEDURE CODE EXCEEDS ONE PER FIVE YEARS SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6242	PROCEDURE CODE EXCEEDS 6 UNITS PER DOS SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6243	PROCEDURE CODE PREVIOUSLY PAID WITHIN A THREE DAY PERIOD	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6244	PROCEDURE CODE EXCEEDS TWO PER LIFETIME SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6245	PROCEDURE CODE EXCEEDS 6 UNITS PER LIFETIME SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6246	PROCEDURE CODE EXCEEDS ONCE PER LIFETIME SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6247	NORPLANT SERVICES LIMITED TO 2 PER FIVE YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6248	PROCEDURE CODE ALLOWED ONCE PER YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6249	PROCEDURE ALLOWED ONCE PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6250	PROCEDURE ALLOWED 10 HOURS (20 UNITS) PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6251	PROCEDURE CODE EXCEEDS 4 PER CALENDAR YEAR SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6252	PSYCHIATRIC SERVICE EXCEEDS ONE UNIT PER DAY SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6253	PROCEDURE CODE EXCEEDS 10 UNITS OF PSYCHOLOGICAL SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6254	MULTIPLE UNITS OF AUTOMATED TESTS CANNOT BE BILLED FOR THE SAME DOS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
6255	PROCEDURE CODE EXCEEDS SCREENING SIGMOIDOSCOPY SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6256	PROCEDURE CODE EXCEEDS ONCE PER CALENDAR YEAR SERVICE LIMIT WITH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6257	ELECTROCONVULSIVE SHOCK THERAPY LIMITED TO 12 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6258	TWELVE NURSING FACILITY VISITS ALLOWED PER STATE FISCAL YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6259	TWELVE OFFICE VISITS ALLOWED PER YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6260	TWELVE PODIATRY NURSING FACILITY VISITS ALLOWED PER STATE FISCAL YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6261	TWELVE PODIATRIST OFFICE VISITS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6262	PSYCHIATRIC EVALUATION LIMITED TO FIVE HOURS PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6263	REDUCED/DENIED PSYCHOLOGY LIMITATION FOR CALENDAR YEAR EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6264	OUTPATIENT PSYCHOTHERAPY LIMITED TO 12 HOURS (24 UNITS PER CALENDAR YE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6265	URINALYSIS LIMITED TO ONE PER ROLLING MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6266	CHOLESTEROL AND LIPIDS LIMITED TO ONE PER ROLLING MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6267	CBC LIMITED TO ONE PER ROLLING MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6268	GROUP OUTPATIENT SERVICES LIMITED TO 20UNITS / 5 HOURS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6269	CRISIS INTERVENTION LIMITED TO 48 UNITS / 12 HOURS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6270	FAMILY OUTPATIENT SERVICES LIMITED TO 16UNITS / 4 HOURS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6271	INDIVIDUAL OUTPATIENT SERVICES LIMITED TO 2 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6272	INTENSIVE FAMILY INTERVENTION LIMITED TO 48 UNITS / 12 HOURS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6273	COMMUNITY SUPPORT-INDIVIDUAL LIMITED TO 48 UNITS/ 12 HOURS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6274	PEER SUPPORT LIMITED TO 48 UNITS / 12 HOURS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6275	ASSERTIVE COMMUNITY TREATMENT LIMITED TO 60 UNITS / 15 HOURS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6276	PSYCHOSOCIAL REHABILITATION LIMITED TO 20 UNITS / 5 HOURS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6277	MH ASSESSMENT BY NON-PHYSICIAN AND SERVICE PLAN DEVELOPMENT LIMITED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6278	PSYCHOLOGICAL TESTING LIMITED TO 5 UNITS/ 5 HOURS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6279	PSYCHIATRIC DIAGNOSTIC EXAM LIMITED TO 2 UNITS PER DAY.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6280	PSYCHIATRIC TREATMENT/MEDICATION MGMT LIMITED TO 1 UNIT PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6281	PROCEDURE CODE EXCEEDS 1 UNIT PER DAY SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6282	PROCEDURE CODE EXCEEDS 155 HOURS PER MONTH SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6283	PROCEDURE CODE EXCEEDS 12 PER DATE OF SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6284	PROCEDURE LIMITED TO 48 UNITS PER DATE OF SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6285	PROCEDURE CODES LIMITED TO THREE (3) UNITS PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6286	PROCEDURE ALLOWED ONCE PER LIFETIME LIMIT EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6287	PROCEDURE LIMITED TO 24 PER DATE OF SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6288	ONLY ONE (1) VISIT ALLOWED PER MONTH OF SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6289	PROCEDURE CODE LIMITED TO ONE (1) PER 180 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6290	PROCEDURE CODE LIMITED TO ONE (1) PER 280 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6291	PROCEDURE CODE LIMITED TO TWO (2) PER 280 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6292	PROCEDURE CODE EXCEEDS 1 UNIT PER MONTH SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6293	REVENUE CODE 942 EXCEEDS 1 UNIT PER YEAR SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6294	LIMITATION ON HOURS FOR ADOLESCENT DAY TREATMENT EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6295	LIMITATION ON HOURS FOR CHILD DAY TREATMENT EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6296	PROCEDURE CODES ALLOWED ONCE PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6297	PROCEDURE CODE EXCEEDS ONE PER CALENDAR YEAR SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6298	PROCEDURE CODE EXCEEDS ONCE EVERY SIX MONTHS SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6299	PROCEDURE LIMITED TO ONE PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6300	PROCEDURE LIMITED TO ONE EVERY THREE MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6302	PROCEDURE CODE EXCEEDS 24 PER DATE OF SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6303	INTENSIVE DAY TREATMENT LIMITED TO 180 UNITS PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6304	PROCEDURE CODE LIMITED TO 1860 UNITS (HOURS) PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6305	ACTIVITIES THERAPY LIMITED TO 360 UNITS PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6306	PROCEDURES LIMITED TO 8 UNITS (2 HOURS) EACH PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6307	AMBULATORY DETOXIFICATION LIMITED TO 960 UNITS PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6308	PROCEDURE LIMITED TO ONE PER 280 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6309	PROCEDURE CODE EXCEEDS SERVICE LIMIT OF ONE PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6310	PROCEDURE WEEKLY LIMIT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6311	CHILDBIRTH EDUCATION LIMITED TO ONE PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6312	DEPO PROVERA INJECTION LIMITED TO 5 UNITS EVERY 365 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6313	CONDOMS LIMITED TO 14 UNITS EVERY 365 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
6314	PROCEDURE CODES RESTRICTED TO SINGLE PROVIDER	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
6315	PROCEDURE LIMITED TO SIX UNITS PER 12 MONTH PERIOD	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6316	PROCEDURE LIMITED TO TWO UNITS PER 12 MONTH PERIOD	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6317	ONLY ONE PROCEDURE CODE ALLOWED PER DATE OF SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6318	AMBULANCE SERVICE IN EXCESS OF TWO TRIPS PER DOS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6319	PROCEDURE LIMITED TO 2976 UNITS PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6320	PROCEDURE LIMITED TO 96 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6321	PROCEDURE CODE LIMITED TO SIX UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6322	PROCEDURE CODES LIMITED TO ONE UNIT PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6323	PROCEDURE CODES LIMITED TO 20 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6324	MORE THAN ONE UNIT PER CALENDAR YEAR IS NOT ALLOWED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6325	THIS HEALTH CHECK PROCEDURE HAS ALREADY BEEN PAID FOR THIS DOS	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
6326	PRIOR APPROVAL REQUIRED FOR MORE THAN 2 UNITS PER ROLLING YEAR	197	Payment adjusted for absence of precertification/ authorization.	M62	Missing/incomplete/invalid treatment authorization code.	CO
6327	PRIOR APPROVAL REQUIRED FOR MORE THAN ONE UNIT EVERY TWO ROLLING YEARS	242	Services not provided by network/primary care providers.	M62	Missing/incomplete/invalid treatment authorization code.	CO
6328	PRIOR AUTHORIZATION WAS NOT OBTAINED WITHIN 72 HOURS	210	Payment adjusted because pre-certification/authorization not received in a timely fashion	M62	Missing/incomplete/invalid treatment authorization code.	CO
6329	PRIOR AUTHORIZATION WAS NOT OBTAINED WITHIN 72 HOURS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
6330	PROCEDURE LIMITED TO 24 UNITS PER ROLLING YEAR WITHOUT OBTAINING PRIOR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6331	PROCEDURE LIMITED TO 2 UNITS PER ROLLING YEAR WITHOUT OBTAINING PRIOR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6332	PROCEDURE LIMITED TO 4 UNITS PER ROLLING YEAR WITHOUT OBTAINING PRIOR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6333	PROCEDURE LIMITED TO 6 UNITS PER ROLLING YEAR WITHOUT OBTAINING PRIOR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6334	PROCEDURE LIMITED TO 124 UNITS PER CALENDAR MONTH WITHOUT OBTAINING PR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6335	PROCEDURE LIMITED TO 10 UNITS PER CALENDAR MONTH WITHOUT OBTAINING PRI	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6336	PROCEDURE LIMITED TO 1 UNIT PER CALENDAR MONTH WITHOUT OBTAINING PRIOR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6337	EACH PROCEDURE LIMITED TO 2 UNITS PER CALENDAR MONTH WITHOUT OBTAINING	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6338	EACH PROCEDURE LIMITED TO 4 UNITS PER CALENDAR MONTH WITHOUT OBTAINING	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6339	PROCEDURE LIMITED TO 5 UNITS PER CALENDAR MONTH WITHOUT OBTAINING PRI	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6340	PROCEDURE LIMITED TO 31 UNITS PER CALENDAR MONTH WITHOUT OBTAINING PRI	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6341	PROCEDURE LIMITED TO 200 UNITS PER CALENDAR MONTH WITHOUT OBTAINING PR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6342	PROCEDURE LIMITED TO 100 UNITS PER CALENDAR MONTH W/O OBTAINING PRIOR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6343	PROCEDURE LIMITED TO 1 UNIT PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6344	PROCEDURE LIMIT OF ONCE PER TWO YEARS HAS BEEN MET	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6345	PROCEDURE LIMIT OF TWO PER 24 MONTHS HAS BEEN MET	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6346	PROCEDURE LIMIT OF FOUR UNITS PER ROLLING YEAR HAS BEEN MET	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6347	ALLOW 1 PER 3 ROLLING YEARS W/O PRIOR AUTHORIZATION	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6348	PROCEDURE BILLED EXCEEDS MAMMOGRAM LIMIT OF ONE PER ROLLING YEAR	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6349	YEARLY MAXIMUM OF $400.00 FOR DME REPAIRS HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6350	RENTAL AMOUNTS TOTAL EXCEEDS PURCHASE PRICE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6351	PROCEDURE LIMIT OF TWICE IN A LIFETIME HAS BEEN MET	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6352	PROCEDURE LIMITED TO ONE PER 90 DAYS WITH CHRONIC RENAL DISEASE DIAG	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6353	PROCEDURE LIMITED TO ONE PER CALENDAR MONTH WITH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6354	HEMO/PERITONEAL DIALYSIS RETRAINING EXCEEDS LIMIT OF 15 UNITS PER LIFE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6355	HEMO DIALYSIS/PERITONEAL/CAPD TRAINING EXCEEDS LIMIT OF ONCE PER LIFET	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6356	FAMILY PLANNING PROCEDURE LIMITED TO ONE PER 11 MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6357	PROCEDURE LIMITED TO ONCE PER 280 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6358	PROCEDURE 90378 LIMITED TO ONCE PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6359	IMMUNIZATION PROCEDURE CODES ALLOWED EIGHT TIMES PER MEMBER LIFETIME -	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6360	SNU MAX DAYS EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6361	TWELVE FAMILY PLANNING VISITS ALLOWED PER FISCAL YEAR - SUSPEND	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6362	TWELVE FAMILY PLANNING LAB PROCEDURES ALLOWED PER STATE FISCAL YEAR	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6363	TWELVE ORAL SURGERY OFFICE VISITS ALLOWED PER STATE FISCAL YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6364	OB ULTRASOUND LIMITED TO THREE PER PREGNANCY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6365	OB ULTRASOUND LIMITED TO ONE PER 280 DAYS W/OUT PA	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6367	SUSPECT PROCEDURE PREVIOUSLY PAID WITHIN A ROLLING THIRTY DAY PERIOD	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
6368	PROCEDURE PREVIOUSLY PAID WITHIN A ROLLING THIRTY DAY PERIOD	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
6369	ASSISTANT SURGEON FEE HAS BEEN PAID FOR THIS PREGNANCY	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
6370	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO 1 UNIT PER MONTH.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6371	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO $7500 PER 366 DAYS.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6372	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO $10,000 PER 366 DAYS.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6373	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO $300 PER 366 DAYS.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6374	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO $5000 PER 366 DAYS.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6375	THIS PROCEDURE CODE IS LIMITED TO 14 UNITS PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6376	THIS PROCEDURE CODE IS LIMITED TO 1 UNIT PER 8 YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6377	PAYMENT REDUCED - PLAN LEAVE LIMITS EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6378	PAYMENT REDUCED - PLAN LEAVE LIMITS EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6379	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO 52 PER 365 DAYS.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6380	TWO CASE MANAGEMENT CLAIMS CANNOT BE PAID FOR THE SAME CALENDAR MONTH	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO
6381	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO LIMIT 7 UNITS PER DAY.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6382	PROCEDURE A9150 U1 LIMITED TO $300 PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6383	INCOMPLETE HEALTH CHECK EXAM; BLOOD LEAD LEVEL NOT DONE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N78	The necessary components of the child and teen checkup (EPSDT) were not completed.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6384	DENTAL SERVICE NOT COVERED DUE TO PAID HYSTERECTOMY OR STERILIZATION	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	OA
6385	VISITS/H AND P/CONSULTATION INCLUDED IN SURGERY REIMBURSEMENT - DO NOT	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	OA
6386	CASE MANAGEMENT CLAIM CANNOT BE BILLED IN THE SAME CALENDAR MONTH AS A	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N20	Service not payable with other service rendered on the same date.	CO
6387	MEMBER READMITTED WITHIN 72 HOURS OF DISCHARGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA40	Missing/incomplete/invalid admission date.	CO
6389	LIMIT OF 2 UNITS OF PROCEDURE CODE 99601 ALLOWED PER DOS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6390	REIMBURSEMENT OF PROCEDURE CODES 99601 AND 99602 IS LIMITED TO 12 UNIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6391	PSYCHIATRIC DIAGNOSTIC ASSESSMENT OR TELEMEDICINE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6392	MH ASSESSMENT BY NON-PHYSICIAN LIMITED TO 10 UNITS PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6393	MH SERVICE PLAN DEVELOPMENT LIMITED TO 4 UNITS PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6394	INDIVIDUAL OUTPATIENT SERVICES LIMITED TO 10 UNITS PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6395	FAMILY OUTPATIENT SERVICE LIMITED TO 10 UNITS PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6396	THERAPY WITH EVALUATION AND MANAGEMENT	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6397	PHARMACOLOGICAL MANAGEMENT OR TELEMEDICINE 2 UNITS PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6398	CRISIS INTERVENTION LIMITED TO 2 UNITS PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6399	POST-OPERATIVE CARE BY NON-OPERATING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N90	Covered only when performed by the attending physician.	CO
6400	THE ALS SERVICE IS LIMITED TO A DAILY AMOUNT OF $70.00	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6401	CONTINUOUS CARE LIMITED TO 24 HOURS PER DATE OF SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6402	CONTINUOUS CARE LIMITED TO 3 CALENDAR DAYS PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6403	MEDICARE PART A DEDUCTIBLE MET FOR BENEFIT PERIOD	1	Deductible Amount	N59	Please refer to your provider manual for additional program and provider information.	PR
6404	LIFETIME UNITS EXCEEDED	35	Lifetime benefit maximum has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6405	MONTHLY UNITS EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6406	LIFETIME UNITS EXCEEDED	35	Lifetime benefit maximum has been reached.	N117	This service is paid only once in a patient's lifetime.	CO
6407	PROCEDURE 96110 LIMIT EXCEEDED FOR AGE RANGE	35	Lifetime benefit maximum has been reached.	N117	This service is paid only once in a patient's lifetime.	CO
6408	PROCEDURE 96110 LIMIT EXCEEDED FOR AGE RANGE	35	Lifetime benefit maximum has been reached.	N117	This service is paid only once in a patient's lifetime.	CO
6409	PROCEDURE 96110 LIMIT EXCEEDED FOR AGE RANGE	35	Lifetime benefit maximum has been reached.	N117	This service is paid only once in a patient's lifetime.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6410	HEALTH AND WELLNESS SUPPORT LIMITED TO 6 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6411	SUB-ACUTE AND ACUTE DETOX LIMITED TO 1 UNIT PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6412	PSYCHOSOCIAL REHAB (15 MIN) LIMITED TO 48 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6413	PSYCHOSOCIAL REHAB (HOURLY) LIMITED TO 5 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6414	CASE MANAGEMENT SERVICES LIMITED TO 24 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6415	PEER SUPPORT (HOURLY) LIMITED TO 5 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6416	PEER SUPPORT (15 MIN) LIMITED TO 48 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6417	ASSERTIVE COMMUNITY TREATMENT (GROUP) LIMITED TO 20 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6418	COMMUNITY LIVING SUPPORT (PER DIEM) LIMITED TO 1 UNIT PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6419	COMMUNITY LIVING SUPPORT (15 MIN) LIMITED TO 10 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6420	TASK-ORIENTED SERVICES LIMITED TO 8 UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6421	CASE MNGMT SERVICES MONTHLY UNIT LIMIT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6422	PROCEDURE T2025 YEARLY UNIT LIMIT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6423	PROCEDURE H2023 DAILY UNIT LIMIT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6424	PROCEDURE T2038 YEARLY AMOUNT LIMIT HAS BEEN REACHED, AGE 0-15	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6425	PROCEDURE T2038 YEARLY AMOUNT LIMIT HAS BEEN REACHED, AGE 16-21	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6426	H0038 HA OR UC DAILY UNIT LIMIT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6427	PROCEDURE T2028 YEARLY AMOUNT LIMIT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6428	PROCEDURE H2019 DAILY UNIT LIMIT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6429	PROCEDURE G0176 DAILY UNIT LIMIT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6430	PROCEDURE T2003 YEARLY AMOUNT LIMIT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6431	FAMILY PEER SUPPORT SERVICES DAILY UNIT LIMIT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6432	PROCEDURE S5150 DAILY UNIT LIMIT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6433	PROCEDURE S5151 DAILY UNIT LIMIT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6434	PROCEDURE H2019 DAILY UNIT LIMIT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6435	PROCEDURE T2040 MONTHLY UNIT LIMIT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6436	CRISIS INTERVENTION LIMITED TO TWO UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6437	CRISIS INTERVENTION LIMITED TO ONE UNIT PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6438	CRISIS INTERVENTION LIMITED TO FOUR UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6439	CRISIS INTERVENTION LIMITED TO EIGHT UNITS PER CAL MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6440	INTERACTIVE COMPLEXITY LIMITED TO FOUR UNITS PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6441	PSYCHIATRIC TREATMENT (WITH/EM) LIMITED TO ONE UNIT/DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6442	PROCEDURE E0202 LIMITED TO 5 UNITS PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6443	VACCINE PRODUCT DAILY UNIT LIMIT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6444	PROCEURE 90460 LIMITED TO 8 PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6445	PROCEURE 90474 LIMITED TO 1 PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6446	PROCEURE 90471 AND 90473 LIMITED TO ANY COMBINATION OF 1 PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6447	PROCEDURE G0151-G0156 LIMITED TO 3 EACH PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6448	PROCEDURE S9122-S9124 LIMITED TO ANY COMBINATION OF 6 PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6475	PRE-OP CARE BY NON-OPERATING PROVIDER-P/R	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N90	Covered only when performed by the attending physician.	CO
6481	POST-OP CARE BY NON-OPERATING PROVIDER-P/R	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N90	Covered only when performed by the attending physician.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6482	PRE-OP CARE BY NON-OPERATING PROVIDER-P/R	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N90	Covered only when performed by the attending physician.	CO
6499	POST-OP CARE BY NON-OP-P/R	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N90	Covered only when performed by the attending physician.	CO
6500	DAILY LIMIT FOR DRUG HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6501	LIMIT FOR FLU VACCINE HAS BEEN REACHED	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6502	LIMIT FOR FLU ADMIN CODE HAS BEEN REACHED	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6600	PROCEDURE CODE EXCEEDS 120 UNITS SERVICE LIMIT PER CALENDAR YEAR WITHO	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6601	PROCEDURE CODES LIMITED TO 2 UNITS PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6602	PROCEDURE CODE 92510 LIMITED TO 8 UNITS PER CALENDAR YEAR WITHOUT PRIO	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6604	PROCEDURE CODES LIMITED TO 480 UNITS PER CALENDAR YEAR WITHOUT PRIOR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6605	PROCEDURE LIMITED TO 40 UNITS PER CALENDAR MONTH W/O PA AND PROCEDURE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6606	PROCEDURE CODES LIMITED TO 3 UNITS PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6607	PROCEDURE CODE LIMITED TO 10 UNITS PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6608	PROCEDURE LIMITED TO 125 UNITS PER CALENDAR YEAR UNLESS PRIOR APPROVA	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6609	PROCEDURE LIMITED TO 4 UNITS PER CALENDAR YEAR UNLESS PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6610	PROCEDURE LIMITED TO 5 VISITS PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6611	PROCEDURE LIMIT HAS BEEN REACHED FOR CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6612	PROCEDURE LIMITED TO 2 UNITS PER CALENDAR YEAR UNLESS PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6613	PROCEDURE LIMITED TO 360 UNITS PER CALENDAR YEAR UNLESS PRIOR APPROVA	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6614	PROCEDURE CODE LIMITED TO ONE PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6616	PROCEDURE CODE LIMITED TO ONE PER 90 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6617	PROCEDURE Y0188 SC OR G9001/HT/TS LIMITED TO ONCE PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6618	PROCEDURE 96151 IS LIMITED TO ONCE PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6619	PROCEDURE MONTHLY LIMIT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6621	COS 960 MAY BILL UP TO 360 UNITS OF SPECIALIZED TRANSPORTATION PER CAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6622	COMPREHENSIVE VISIT Y0186 (SC), T2023/U1, T2023/U2, OR G9001/HT LIMI	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6623	PROCEDURE CODE Y0187 SC, T2023/U1/TS, OR T1016 LIMITED TO 40 UNITS PER	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6624	PROCEDURE CODES LIMITED TO 240 UNITS PER CALENDAR YEAR WITHOUT PA	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6625	LIMITED TO 40 UNITS PER MONTH W/O PA	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6626	PROCEDURE LIMITED TO 20 UNITS PER CALENDAR MONTH W/O PA	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6627	PROCEDURE LIMITED TO 4 UNITS PER DATE OF SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6628	PROCEDURE CODE LIMITED TO 1 UNIT PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6629	COMBINATION OF PROCEDURE CODES LIMITED TO 2 PER DAY CIS/CISS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6630	PROCEDURE CODE LIMITED TO ONCE PER 180 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6631	PROCEDURE CODES LIMITED TO 7 UNITS PER CALENDAR YEAR WITHOUT PA	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6632	PROCEDURE LIMITED TO 8 UNITS PER MONTH WITHOUT A PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6633	PROCEDURE LIMITED TO 96 UNITS PER YEAR WITHOUT A PRIOR AUTHORIZATION	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6634	PROCEDURES LIMITED TO 120 UNITS PER CALENDAR YEAR W/O PA	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6651	CLAIM DENIED. ATTACHMENT NOT RECEIVED WITHIN 30 DAYS.	164	Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion.	N223	Missing documentation of benefit to the patient during initial treatment period.	CO
6658	DUPLICATE DENTAL RESIN WITHIN THREE YEARS	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
6700	LIMITS FOR PSYCHOLOGY AND PSYCHIATRIC SERVICES HAVE BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6701	REPEAT SURGICAL PROCEDURE WITHIN 2 DAYS REQUIRES REVIEW	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N35	Program integrity/utilization review decision.	CO
6702	PROCEDURE CODES Y0187 SC, T2023/U1/TS, OR T1016 LIMITED TO 4 UNITS PER	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6703	MEDICARE DEDUCTIBLE AMOUNT EXCEEDS CALENDAR YEAR ALLOWABLE	1	Deductible Amount	N59	Please refer to your provider manual for additional program and provider information.	PR
6704	MEDICARE DEDUCTIBLE AMOUNT EXCEEDS ALLOWABLE	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N408	This payer does not cover deductibles assessed by a previous payer.	CO
6706	NURSING FACILITY CLAIM CONFLICTS WITH PREVIOUSLY PAID INPATIENT CLAIM	166	These services were submitted after this payers responsibility for processing claims under this plan ended.	MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	CO
6708	PERSONAL ASSISTANCE RETAINER WHILE MEMBER IS IN THE HOSPITAL OR NURSIN	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6709	AMBULANCE MILEAGE PROCEDURE CODE CANNOT BE BILLED WITHOUT BASE RATE PR	B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N390	This service cannot be billed separately.	OA
6712	TWELVE FAMILY PLANNING VISITS ALLOWED PER STATE FISCAL YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6717	LIMITS FOR SMOKING CESSATION SERVICES HAVE BEEN EXCEEDED FOR THIS PREG	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6718	99406 AND 99407 SERVICES LIMITED TO ONE OF EITHER PROCEDURE PER 30 DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
6719	SERVICE LIMITED TO 3 PER 90 DAY PERIOD	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
6720	INPATIENT INTERIM CLAIM REPLACEMENT NOT VALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N152	Missing/incomplete/invalid replacement claim information.	CO
6721	INPATIENT FINAL CLAIM REPLACEMENT NOT VALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N152	Missing/incomplete/invalid replacement claim information.	CO
6861	PROCEDURE INVALID IN NURSING HOME	5	The procedure code/bill type is inconsistent with the place of service.	M77	Missing/incomplete/invalid place of service.	CO
6863	POSSIBLE DUPLICATE CONFLICT. MAY BE A CONFLICT WITH ANOTHER PROVIDERS	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
7000	CLAIM FAILED A PRODUR ALERT	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N349	The administration method and drug must be reported to adjudicate this service.	CO
7010	TOTAL UNITS GREATER THAN TOTAL DAYS	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M53	Missing/incomplete/invalid days or units of service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
7207	PROCEDURE IS CLASSIFIED AS A COSMETIC PROCEDURE	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N383	Services deemed cosmetic are not covered	CO
7208	PROCEDURE IS AN UNLISTED PROCEDURE	189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service	N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or an Unlisted procedure.	CO
7209	PROCEDURE IS CLASSIFIED AS EXPERIMENTAL	55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.	N356	This service is not covered when performed with, or subsequent to, a non-covered service.	CO
7210	PROCEDURE IS CLASSIFIED AS OBSOLETE	181	Payment adjusted because this procedure code was invalid on the date of service	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
7211	PROCEDURE IS INVALID FOR PATIENTS AGE	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
7212	PROCEDURE ADDED DUE TO ALTERNATE CODE REPLACEMENT (AGE)	220	The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Workers Compensation only)	N22	This procedure code was added/changed because it more accurately describes the services rendered.	CO
7213	PROCEDURE IS INVALID FOR PATIENTS SEX	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303	CO
7214	PROCEDURE ADDED DUE TO ALTERNATE CODE REPLACEMENT (SEX)	7	The procedure/revenue code is inconsistent with the patient's gender.	N22	This procedure code was added/changed because it more accurately describes the services rendered.	CO
7215	PROCEDURE CODE IS INCIDENTAL	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N19	Procedure code incidental to primary procedure.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
7216	VISIT PROCEDURE CODE IS NOT INDICATED FOR SEPARATE REIMBURSEMENT	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	M86	Service denied because payment already made for same/similar procedure within set time frame.	OA
7261	AMBULATORY SURGERY-EXACT DUPLICATE OF ANOTHER CLAIM	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
7278	THE MEMBER DATE OF BIRTH IS MISSING OR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N329	Missing/incomplete/invalid patient birth date.	CO
7707	PROCEDURE CODE LIMITED TO 120 UNITS PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
7890	CLAIM PAID TEMPORARILY. EXPECT CLAIM TO BE ADJUSTED IN THE FUTURE.	101	Predetermination: anticipated payment upon completion of services or claim adjudication.	N59	Please refer to your provider manual for additional program and provider information.	CO
8001	PAYER HIERARCHY NOT FOUND	147	Provider contracted/negotiated rate expired or not on file.	N36	Claim must meet primary payer&#65533;s processing requirements before we can consider payment.	CO
8008	PROVIDER REQUESTED CLAIM ADJUSTMENT DUE TO MISC OR UNSPECIFIED ERROR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
8034	PROVIDER REQUESTED OFFSET DUE TO SPENDDOWN	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N59	Please refer to your provider manual for additional program and provider information.	OA
8035	PROVIDER REQUESTED OFFSET DUE TO AUTO LIABILITY	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N59	Please refer to your provider manual for additional program and provider information.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8036	PROVIDER REQUESTED OFFSET DUE TO WORKERS COMP	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N59	Please refer to your provider manual for additional program and provider information.	OA
8037	PROVIDER REQUESTED CLAIM VOID DUE TO BILLING ERROR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N59	Please refer to your provider manual for additional program and provider information.	OA
8038	PROVIDER REQUESTED OFFSET DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N59	Please refer to your provider manual for additional program and provider information.	OA
8070	PROVIDER SENT REFUND DUE TO MEDICAID FRAUD	150	Payment adjusted because the payer deems the information submitted does not support this level of service.	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	CO
8071	PROVIDER SENT REFUND PAYMENT DUE TO MEDICAID FRAUD	150	Payment adjusted because the payer deems the information submitted does not support this level of service.	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	CO
8072	PROVIDER SENT REFUND DUE TO AUTO LIABILITY	215	Based on subrogation of a third party settlement	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	OA
8073	PROVIDER SENT REFUND DUE TO WORKERS COMP.	19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	OA
8074	PROVIDER SENT REFUND FOR CLAIM NOT IN HISTORY	150	Payment adjusted because the payer deems the information submitted does not support this level of service.	N59	Please refer to your provider manual for additional program and provider information.	CO
8201	TPL PRIVATE HEALTH INSURANCE - PROVIDER	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
8202	TPL PRIVATE HEALTH INSURANCE - MEMBER	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8203	AUTO LIABILITY - CARRIER	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
8204	AUTO LIABILITY - PROVIDER	20	Claim denied because this injury/illness is covered by the liability carrier.	N437	Alert: If the injury claim is accepted, these charges will be reconsidered.	OA
8205	AUTO LIABILITY - MEMBER	20	Claim denied because this injury/illness is covered by the liability carrier.	N437	Alert: If the injury claim is accepted, these charges will be reconsidered.	OA
8206	NON-AUTO LIABILITY - CARRIER	20	Claim denied because this injury/illness is covered by the liability carrier.	N437	Alert: If the injury claim is accepted, these charges will be reconsidered.	OA
8207	NON-AUTO LIABILITY - PROVIDER	20	Claim denied because this injury/illness is covered by the liability carrier.	N437	Alert: If the injury claim is accepted, these charges will be reconsidered.	OA
8208	NON-AUTO LIABILITY - MEMBER	20	Claim denied because this injury/illness is covered by the liability carrier.	N437	Alert: If the injury claim is accepted, these charges will be reconsidered.	OA
8209	WORKERS COMP - CARRIER	19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	N59	Please refer to your provider manual for additional program and provider information.	OA
8210	WORKERS COMP - PROVIDER	19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	N59	Please refer to your provider manual for additional program and provider information.	OA
8212	PROBATES ESTATE	147	Provider contracted/negotiated rate expired or not on file.	N59	Please refer to your provider manual for additional program and provider information.	CO
8213	INCOME PENSION TRUST RECOVERIES	147	Provider contracted/negotiated rate expired or not on file.	N59	Please refer to your provider manual for additional program and provider information.	CO
8214	VICTIMS RESTITUTION	147	Provider contracted/negotiated rate expired or not on file.	N59	Please refer to your provider manual for additional program and provider information.	CO
8217	DUE TO MISCELLANEOUS OR UNSPECIFIED REASON	147	Provider contracted/negotiated rate expired or not on file.	N59	Please refer to your provider manual for additional program and provider information.	CO
8225	CAPITATION - DEATH OF MEMBER	166	These services were submitted after this payers responsibility for processing claims under this plan ended.	N30	Patient ineligible for this service.	CO

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8226	CAPITATION - MEMBER INCARCERATED	166	These services were submitted after this payers responsibility for processing claims under this plan ended.	N103	Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while they are in State or local custody under a penal authority, unless under State or local law, the individual is personally	CO
8227	CAPITATION - EPSDT CLAIM	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	N59	Please refer to your provider manual for additional program and provider information.	OA
8228	CAPITATION - MEMBER ENROLLED IN ERROR	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	N59	Please refer to your provider manual for additional program and provider information.	OA
8229	CAPITATION - FAMILY PLANNING	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
8230	CAPITATION - INCORRECT RATE CATEGORY	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	N59	Please refer to your provider manual for additional program and provider information.	OA
8231	CAPITATION - DEMOGRAPHIC CHANGE	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	N59	Please refer to your provider manual for additional program and provider information.	OA
8232	CAPITATION - OTHER	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	N59	Please refer to your provider manual for additional program and provider information.	OA
8234	TPL VENDOR VOID	147	Provider contracted/negotiated rate expired or not on file.	N377	Payment adjusted based on a processed replacement claim.	CO
8240	ADJUSTMENT GENERATED DUE TO SURS REVIEW	147	Provider contracted/negotiated rate expired or not on file.	N59	Please refer to your provider manual for additional program and provider information.	CO
8241	ADJUSTMENT GENERATED DUE TO CHANGE IN PATIENT LIABILITY	142	Claim adjusted by the monthly Medicaid patient liability amount.	N59	Please refer to your provider manual for additional program and provider information.	PR
8242	ADJUSTMENT GENERATED DUE TO RATE CHANGE	147	Provider contracted/negotiated rate expired or not on file.	N59	Please refer to your provider manual for additional program and provider information.	CO
8244	PAYOUT PROCESSED DUE TO DISPROPORTIONATE SHARE	76	Disproportionate Share Adjustment.	N59	Please refer to your provider manual for additional program and provider information.	CO
8245	POINT OF SALE	147	Provider contracted/negotiated rate expired or not on file.	N59	Please refer to your provider manual for additional program and provider information.	CO
8246	POINT OF SALE REVERSAL	147	Provider contracted/negotiated rate expired or not on file.	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8247	ADJUSTMENT GENERATED DUE TO ACS RATE CHANGE	147	Provider contracted/negotiated rate expired or not on file.	N59	Please refer to your provider manual for additional program and provider information.	CO
8248	ADJUSTMENT GENERATED DUE TO UCC RATE CHANGE	147	Provider contracted/negotiated rate expired or not on file.	N59	Please refer to your provider manual for additional program and provider information.	CO
8286	MEMBER HAS VERIFIED INSURANCE COMPANY	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
8287	CHECK HISTORY MASS VOID	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
8288	AUTO RECOUPMENT, SYSTEM CHARGE	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
8289	AUTO RECOUPMENT, SYSTEM ERROR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
8290	DCH ORDERED REPROCESSED CLAIMS	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
8291	COURT ORDERED SETTLEMENT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
8293	CLAIM ADJUSTMENT VIA TPL BILLING FILE	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
8294	CREDIT BALANCE FROM EDS - HP	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
8295	CHANGE IN PATIENT RESOURCES	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA

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8296	INSTITUTIONAL CARE PROVIDER CHANGE OF OWNERSHIP	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
8298	LTCF OV TRANSACTION CODE CREDIT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
8401	DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. T	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N59	Please refer to your provider manual for additional program and provider information.	OA
8402	DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE A	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	OA
8403	DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N59	Please refer to your provider manual for additional program and provider information.	OA
8404	DUE TO A LIABILITY AND CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N59	Please refer to your provider manual for additional program and provider information.	OA
8405	DUE TO A LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N59	Please refer to your provider manual for additional program and provider information.	OA
8407	RELEASE OF LIEN RECEIVED BY LIEN HOLDER	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N59	Please refer to your provider manual for additional program and provider information.	OA
8408	DECREASE TO ORIGINAL LIEN AMOUNT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N59	Please refer to your provider manual for additional program and provider information.	OA
8409	INCREASE TO ORIGINAL LIEN AMOUNT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N59	Please refer to your provider manual for additional program and provider information.	OA
8420	AS THE RESULT OF AN AUDIT DIVISION REVIEW, AN ACCOUNTS RECEIVABLE HAS	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8421	AS THE RESULT OF CLAIMS PROCESSING ERROR, AN ACCOUNTS RECEIVABLE HAS B	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	OA
8424	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/CHILD WELFARE.	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	OA
8427	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DRUG REBATE	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	OA
8431	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MANAGED CARE ADJUST	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	N423	Claim payment was the result of a payer's retroactive adjustment due to a non standard program.	OA
8432	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MEDICAID FRAUD	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	OA
8515	THIS CLAIM HAS BEEN DENIED DUE TO A REVERSAL TRANSACTION	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N142	The original claim was denied. Resubmit a new claim, not a replacement claim.	CO
8600	01-M/I BIN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8601	02-M/I VERSION NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8602	03-M/I TRANSACTION CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8603	04-M/I PROCESSOR CONTROL NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8604	05-M/I PHARMACY NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N31	Missing/incomplete/invalid prescribing provider identifier.	CO
8605	06-M/I GROUP NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA112	Missing/incomplete/invalid group practice information.	CO
8606	07-M/I CARDHOLDER ID NUMBER	31	Claim denied as patient cannot be identified as our insured.	N59	Please refer to your provider manual for additional program and provider information.	CO
8607	08-M/I PERSON CODE	31	Claim denied as patient cannot be identified as our insured.	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8608	09-M/I BIRTH DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N329	Missing/incomplete/invalid patient birth date.	CO
8609	1C-M/I SMOKER/NON-SMOKER CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
8610	1E-M/I PRESCRIBER LOCATION CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N180	This item or service does not meet the criteria for the category under which it was billed.	CO
8611	10-M/I PATIENT GENDER CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA39	Missing/incomplete/invalid gender.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8612	11-M/I PATIENT RELATIONSHIP CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA60	Missing/incomplete/invalid patient relationship to insured.	CO
8613	12-M/I PATIENT LOCATION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N79	Service billed is not compatible with patient location information.	CO
8614	13-M/I OTHER COVERAGE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N245	Incomplete/invalid plan information for other insurance	CO
8615	14-M/I ELIGIBILITY CLARIFICATION CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N30	Patient ineligible for this service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8616	15-M/I DATE OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M52	Missing/incomplete/invalid 'from' date(s) of service.	CO
8617	16-M/I PRESCRIPTION/SERVICE REFERENCE NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N388	Missing/incomplete/invalid prescription number	CO
8618	17-M/I FILL NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N388	Missing/incomplete/invalid prescription number	CO
8619	19-M/I DAYS SUPPLY	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N378	Missing/incomplete/invalid prescription quantity.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8620	2C-M/I PREGNANCY INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8621	2E-M/I PRIMARY CARE PROVIDER ID QUALIFIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO
8622	20-M/I COMPOUND CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
8623	21-M/I PRODUCT/SERVICE ID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8624	22-M/I DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	CO
8625	23-M/I INGREDIENT COST SUBMITTED	90	Ingredient cost adjustment.	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	CO
8626	25-M/I PRESCRIBER ID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N31	Missing/incomplete/invalid prescribing provider identifier.	CO
8627	26-M/I UNIT OF MEASURE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	CO
8628	28-M/I DATE PRESCRIPTION WRITTEN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N57	Missing/incomplete/invalid prescribing date. (Modified 12/2/04) Related to N304	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8629	29-M/I NUMBER REFILLS AUTHORIZED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	CO
8630	3A-M/I REQUEST TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8631	3B-M/I REQUEST PERIOD DATE-BEGIN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO
8632	3C-M/I REQUEST PERIOD DATE-END	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8633	3D-M/I BASIS OF REQUEST	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8634	3E-M/I AUTHORIZED REPRESENTATIVE FIRST NAME	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N256	Missing/incomplete/invalid billing provider/supplier name.	CO
8635	3F-M/I AUTHORIZED REPRESENTATIVE LAST NAME	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N256	Missing/incomplete/invalid billing provider/supplier name.	CO
8636	3G-M/I AUTHORIZED REPRESENTATIVE STREET ADDRESS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N258	Missing/incomplete/invalid billing provider/supplier address.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8637	3H-M/I AUTHORIZED REPRESENTATIVE CITY ADDRESS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N258	Missing/incomplete/invalid billing provider/supplier address.	CO
8638	3J-M/I AUTHORIZED REPRESENTATIVE STATE/PROVINCE ADDRESS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N258	Missing/incomplete/invalid billing provider/supplier address.	CO
8639	3K-M/I AUTHORIZED REPRESENTATIVE ZIP/POSTAL ZONE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N258	Missing/incomplete/invalid billing provider/supplier address.	CO
8640	3M-M/I PRESCRIBER PHONE NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N258	Missing/incomplete/invalid billing provider/supplier address.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8641	3N-M/I PRIOR AUTHORIZED NUMBER ASSIGNED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M62	Missing/incomplete/invalid treatment authorization code.	CO
8642	3P-M/I AUTHORIZATION NUMBER	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
8643	3R-PRIOR AUTHORIZATION NOT REQUIRED	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
8644	3S-M/I PRIOR AUTHORIZATION SUPPORTING DOCUMENTATION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	CO
8645	3T-ACTIVE PRIOR AUTHORIZATION EXISTS RESUBMIT AT EXPIRATION OF PRIOR A	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
8646	3W-PRIOR AUTHORIZATION IN PROCESS	197	Payment adjusted for absence of precertification/ authorization.	M62	Missing/incomplete/invalid treatment authorization code.	CO
8647	3X-AUTHORIZATION NUMBER NOT FOUND	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
8648	3Y-PRIOR AUTHORIZATION DENIED	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8649	32-M/I LEVEL OF SERVICE	150	Payment adjusted because the payer deems the information submitted does not support this level of service.	M26	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refun	CO
8650	33-M/I PRESCRIPTION ORIGIN CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N388	Missing/incomplete/invalid prescription number	CO
8651	34-M/I SUBMISSION CLARIFICATION CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8652	35-M/I PRIMARY CARE PROVIDER ID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8653	38-M/I BASIS OF COST	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8654	39-M/I DIAGNOSIS CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
8655	4C-M/I COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N180	This item or service does not meet the criteria for the category under which it was billed.	CO
8656	4E-M/I PRIMARY CARE PROVIDER LAST NAME	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N256	Missing/incomplete/invalid billing provider/supplier name.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8657	40-PHARMACY NOT CONTRACTED WITH PLAN ON DATE OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N280	Missing/incomplete/invalid pay-to provider primary identifier.	CO
8658	41-SUBMIT BILL TO OTHER PROCESSOR OR PRIMARY PAYER	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO
8659	5C-M/I OTHER PAYER COVERAGE TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N48	Claim information does not agree with information received from other insurance carrier.	CO
8660	5E-M/I OTHER PAYER REJECT COUNT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8661	50-NON-MATCHED PHARMACY NUMBER	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N31	Missing/incomplete/invalid prescribing provider identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8662	51-NON-MATCHED GROUP ID	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA112	Missing/incomplete/invalid group practice information.	CO
8663	52-NON-MATCHED CARDHOLDER ID	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N382	Missing/incomplete/invalid patient identifier.	CO
8664	53-NON-MATCHED PERSON CODE	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N382	Missing/incomplete/invalid patient identifier.	CO
8665	54-NON-MATCHED PRODUCT/SERVICE ID NUMBER	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N59	Please refer to your provider manual for additional program and provider information.	CO
8666	55-NON-MATCHED PRODUCT PACKAGE SIZE	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	CO
8667	56-NON-MATCHED PRESCRIBER ID	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N31	Missing/incomplete/invalid prescribing provider identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8668	57-NON-MATCHED P.A./M.C. NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M62	Missing/incomplete/invalid treatment authorization code.	CO
8669	58-NON-MATCHED PRIMARY PRESCRIBER	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N31	Missing/incomplete/invalid prescribing provider identifier.	CO
8670	6C-M/I OTHER PAYER ID QUALIFIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N245	Incomplete/invalid plan information for other insurance	CO
8671	6E-M/I OTHER PAYER REJECT CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8672	60-PRODUCT/SERVICE NOT COVERED FOR PATIENT AGE	6	The procedure/revenue code is inconsistent with the patient's age.	N59	Please refer to your provider manual for additional program and provider information.	CO
8673	61-PRODUCT/SERVICE NOT COVERED FOR PATIENT GENDER	7	The procedure/revenue code is inconsistent with the patient's gender.	MA39	Missing/incomplete/invalid gender.	CO
8674	62-PATIENT/CARD HOLDER ID NAME MISMATCH	140	Patient/Insured health identification number and name do not match.	N382	Missing/incomplete/invalid patient identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8675	63-INSTITUTIONALIZED PATIENT PRODUCT/SERVICE ID NOT COVERED	58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.	CO
8676	64-CLAIM SUBMITTED DOES NOT MATCH PRIOR AUTHORIZATION	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
8677	65-PATIENT IS NOT COVERED	177	Payment denied because the patient has not met the required eligibility requirements	N30	Patient ineligible for this service.	CO
8678	66-PATIENT AGE EXCEEDS MAXIMUM AGE	32	Our records indicate that this dependent is not an eligible dependent as defined.	N59	Please refer to your provider manual for additional program and provider information.	CO
8679	67-FILLED BEFORE COVERAGE EFFECTIVE	26	Expenses incurred prior to coverage.	N30	Patient ineligible for this service.	CO
8680	68-FILLED AFTER COVERAGE EXPIRED	27	Expenses incurred after coverage terminated.	N30	Patient ineligible for this service.	CO
8681	69-FILLED AFTER COVERAGE TERMINATED	27	Expenses incurred after coverage terminated.	N30	Patient ineligible for this service.	CO
8682	7C-M/I OTHER PAYER ID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N48	Claim information does not agree with information received from other insurance carrier.	CO
8683	7E-M/I DUR/PPS CODE COUNTER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
8684	70-PRODUCT/SERVICE NOT COVERED	204	This service/equipment/drug is not covered under the patient&#65533;s current benefit plan	N431	Service is not covered with this procedure.	CO
8685	71-PRESCRIBER IS NOT COVERED	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N31	Missing/incomplete/invalid prescribing provider identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8686	72-PRIMARY PRESCRIBER IS NOT COVERED	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N77	Missing/incomplete/invalid designated provider number.	CO
8687	73-REFILLS ARE NOT COVERED	204	This service/equipment/drug is not covered under the patient's current benefit plan	N431	Service is not covered with this procedure.	CO
8688	74-OTHER CARRIER PAYMENT MEETS OR EXCEEDS PAYABLE	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N131	Total payments under multiple contracts cannot exceed the allowance for this service.	OA
8689	75-PRIOR AUTHORIZATION REQUIRED	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
8690	76-PLAN LIMITATIONS EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
8691	77-DISCONTINUED PRODUCT/SERVICE ID NUMBER	203	Payment adjusted for discontinued or reduced service.	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
8692	78-COST EXCEEDS MAXIMUM	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N524	Based on policy this payment constitutes payment in full.	CO
8693	79-REFILL TOO SOON	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.	CO
8694	8C-M/I FACILITY ID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N293	Missing/incomplete/invalid service facility primary identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8695	8E-M/I DUR/PPS LEVEL OF EFFORT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
8696	80-DRUG-DIAGNOSIS MISMATCH	11	The diagnosis is inconsistent with the procedure.	N59	Please refer to your provider manual for additional program and provider information.	CO
8697	81-CLAIM TOO OLD	29	The time limit for filing has expired.	N59	Please refer to your provider manual for additional program and provider information.	CO
8698	82-CLAIM IS POST-DATED	110	Billing date predates service date.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO
8699	83-DUPLICATE PAID/CAPTURED CLAIM	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
8700	84-CLAIM HAS NOT BEEN PAID/CAPTURED	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N36	Claim must meet primary payer&#65533;s processing requirements before we can consider payment.	CO
8701	85-CLAIM NOT PROCESSED	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N36	Claim must meet primary payer&#65533;s processing requirements before we can consider payment.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8702	86-SUBMIT MANUAL REVERSAL	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8703	87-REVERSAL NOT PROCESSED	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8704	88-DUR REJECT ERROR	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8705	89-REJECTED CLAIM FEES PAID	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8706	90-HOST HUNG UP	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8707	91-HOST RESPONSE ERROR	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8708	92-SYSTEM UNAVAILABLE/HOST UNAVAILABLE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8709	95-TIME OUT	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8710	96-SCHEDULED DOWNTIME	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8711	97-PAYER UNAVAILABLE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8712	98-CONNECTION TO PAYER IS DOWN	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8713	99-HOST PROCESSING ERROR	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8714	AA-PATIENT SPENDDOWN NOT MET	142	Claim adjusted by the monthly Medicaid patient liability amount.	N58	Missing/incomplete/invalid patient liability amount.	PR
8716	AC-PRODUCT NOT COVERED NON-PARTICIPATING MANUFACTURER	111	Not covered unless the provider accepts assignment.	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8717	AD-BILLING PROVIDER NOT ELIGIBLE TO BILL THIS CLAIM TYPE	38	Services not provided or authorized by designated (network/primary care) providers.	N34	Incorrect claim form/format for this service.	CO
8718	AE-QMB (QUALIFIED MEDICARE BENEFICIARY)-BILL MEDICARE	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO
8720	AG-DAYS SUPPLY LIMITATION FOR PRODUCT/SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
8721	AH-UNIT DOSE PACKAGING ONLY PAYABLE FOR NURSING HOME RECIPIENTS	58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.	CO
8722	AJ-GENERIC DRUG REQUIRED	204	This service/equipment/drug is not covered under the patient&#65533;s current benefit plan	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
8723	AK-M/I SOFTWARE VENDOR/CERTIFICATION ID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8724	AM-M/I SEGMENT IDENTIFICATION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8725	A9-M/I TRANSACTION COUNT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8726	BE-M/I PROFESSIONAL SERVICE FEE SUBMITTED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N200	The professional component must be billed separately.	CO
8727	B2-M/I SERVICE PROVIDER ID QUALIFIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N283	Missing/incomplete/invalid purchased service provider identifier.	CO
8728	CA-M/I PATIENT FIRST NAME	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA36	Missing/incomplete/invalid patient name.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8729	CB-M/I PATIENT LAST NAME	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA36	Missing/incomplete/invalid patient name.	CO
8730	CC-M/I CARDHOLDER FIRST NAME	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA36	Missing/incomplete/invalid patient name.	CO
8731	CD-M/I CARDHOLDER LAST NAME	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA36	Missing/incomplete/invalid patient name.	CO
8732	CE-M/I HOME PLAN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M135	Missing/incomplete/invalid plan of treatment.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8733	CF-M/I EMPLOYER NAME	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8734	CG-M/I EMPLOYER STREET ADDRESS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8735	CH-M/I EMPLOYER CITY ADDRESS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8736	CI-M/I EMPLOYER STATE/PROVINCE ADDRESS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8737	CJ-M/I EMPLOYER ZIP POSTAL ZONE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8738	CK-M/I EMPLOYER PHONE NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8739	CL-M/I EMPLOYER CONTACT NAME	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8740	CM-M/I PATIENT STREET ADDRESS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA37	Missing/incomplete/invalid patient's address.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8741	CN-M/I PATIENT CITY ADDRESS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA37	Missing/incomplete/invalid patient's address.	CO
8742	CO-M/I PATIENT STATE/PROVINCE ADDRESS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA37	Missing/incomplete/invalid patient's address.	CO
8743	CP-M/I PATIENT ZIP/POSTAL ZONE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA37	Missing/incomplete/invalid patient's address.	CO
8744	CQ-M/I PATIENT PHONE NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA37	Missing/incomplete/invalid patient's address.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8745	CR-M/I CARRIER ID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N245	Incomplete/invalid plan information for other insurance	CO
8746	CW-M/I ALTERNATE ID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N270	Missing/incomplete/invalid other provider primary identifier.	CO
8747	CX-M/I PATIENT ID QUALIFIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA37	Missing/incomplete/invalid patient's address.	CO
8748	CY-M/I PATIENT ID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA37	Missing/incomplete/invalid patient's address.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8749	CZ-M/I EMPLOYER ID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8750	DC-M/I DISPENSING FEE SUBMITTED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement	CO
8751	DN-M/I BASIS OF COST DETERMINATION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8752	DQ-M/I USUAL AND CUSTOMARY CHARGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8753	DR-M/I PRESCRIBER LAST NAME	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N289	Missing/incomplete/invalid rendering provider name.	CO
8754	DT-M/I UNIT DOSE INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	CO
8755	DU-M/I GROSS AMOUNT DUE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO
8756	DV-M/I OTHER PAYER AMOUNT PAID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8757	DX-M/I PATIENT PAID AMOUNT SUBMITTED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO
8758	DY-M/I DATE OF INJURY	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N305	Missing/incomplete/invalid accident date.	CO
8759	DZ-M/I CLAIM/REFERENCE ID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M47	Missing/incomplete/invalid internal or document control number.	CO
8760	EA-M/I ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8761	EB-M/I ORIGINALLY PRESCRIBED QUANTITY	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N378	Missing/incomplete/invalid prescription quantity.	CO
8762	EC-M/I COMPOUND INGREDIENT COMPONENT COUNT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8763	ED-M/I COMPOUND INGREDIENT QUANTITY	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N378	Missing/incomplete/invalid prescription quantity.	CO
8764	EE-M/I COMPOUND INGREDIENT DRUG COST	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8765	EF-M/I COMPOUND DOSAGE FORM DESCRIPTIN CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	CO
8766	EG-M/I COMPOUND DISPENSING UNIT FORM INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8767	EH-M/I COMPOUND ROUTE OF ADMINISTRATION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N349	The administration method and drug must be reported to adjudicate this service.	CO
8768	EJ-M/I ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8769	EK-M/I SCHEDULED PRESCRIPTION ID NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N388	Missing/incomplete/invalid prescription number	CO
8770	EM-M/I PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N388	Missing/incomplete/invalid prescription number	CO
8771	EN-M/I ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N388	Missing/incomplete/invalid prescription number	CO
8772	EP-M/I ASSOCIATED PRESCRIPTION/SERVICE DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N57	Missing/incomplete/invalid prescribing date. (Modified 12/2/04) Related to N304	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8773	ER-M/I PROCEDURE MODIFIER CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N519	Invalid combination of HCPCS modifiers.	CO
8774	ET-M/I QUANTITY PRESCRIBED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N378	Missing/incomplete/invalid prescription quantity.	CO
8775	EU-M/I PRIOR AUTHORIZATION TYPE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M62	Missing/incomplete/invalid treatment authorization code.	CO
8776	EV-M/I PRIOR AUTHORIZATION NUMBER SUBMITTED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M62	Missing/incomplete/invalid treatment authorization code.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8777	EW-M/I INTERMEDIARY AUTHORIZATION TYPE ID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M62	Missing/incomplete/invalid treatment authorization code.	CO
8778	EX-M/I INTERMEDIARY AUTHORIZATION ID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M62	Missing/incomplete/invalid treatment authorization code.	CO
8779	EY-M/I PROVIDER ID QUALIFIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO
8780	EZ-M/I PRESCRIBER ID QUALIFIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M62	Missing/incomplete/invalid treatment authorization code.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8781	E1-M/I PRODUCT/SERVICE ID QUALIFIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
8782	E3-M/I INCENTIVE AMOUNT SUBMITTED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M79	Missing/incomplete/invalid charge.	CO
8783	E4-M/I REASON FOR SERVICE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
8784	E5-M/I PROFESSIONAL SERVICE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8785	E6-M/I RESULT OF SERVICE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301	CO
8786	E7-M/I QUANTITY DISPENSED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N378	Missing/incomplete/invalid prescription quantity.	CO
8787	E8-M/I OTHER PAYER DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N307	Missing/incomplete/invalid adjudication or payment date.	CO
8788	E9-M/I PROVIDER ID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8789	FO-M/I PLAN ID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N245	Incomplete/invalid plan information for other insurance	CO
8790	GE-M/I PERCENTAGE SALES TAX AMOUNT SUBMITTED	235	Sales tax.	M79	Missing/incomplete/invalid charge.	CO
8791	HA-M/I FLAT SALES TAX AMOUNT SUBMITTED	235	Sales tax.	M79	Missing/incomplete/invalid charge.	CO
8792	HB-M/I OTHER PAYER AMOUNT PAID COUNT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N48	Claim information does not agree with information received from other insurance carrier.	CO
8793	HC-M/I OTHER PAYER AMOUNT PAID QUALIFIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N48	Claim information does not agree with information received from other insurance carrier.	CO
8794	HD-M/I DISPENSING STATUS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8795	HE-M/I PERCENTAGE SALES TAX RATE SUBMITTED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8796	HF-M/I QUANTITY INTENDED TO BE DISPENSED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N378	Missing/incomplete/invalid prescription quantity.	CO
8797	HG-M/I DAYS SUPPLY INTENDED TO BE DISPENSED	154	Payment adjusted because the payer deems the information submitted does not support this day's supply.	N378	Missing/incomplete/invalid prescription quantity.	CO
8798	H1-M/I MEASUREMENT TIME	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8799	H2-M/I MEASUREMENT DIMENSION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8800	H3-M/I MEASUREMENT UNIT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M53	Missing/incomplete/invalid days or units of service.	CO
8801	H4-M/I MEASUREMENT VALUE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8802	H5-M/I PRIMARY CARE PROVIDER LOCATION CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N258	Missing/incomplete/invalid billing provider/supplier address.	CO
8803	H6-M/I DUR CO-AGENT ID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8804	H7-M/I OTHER AMOUNT CLAIMED SUBMITTED COUNT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N48	Claim information does not agree with information received from other insurance carrier.	CO
8805	H8-M/I OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N48	Claim information does not agree with information received from other insurance carrier.	CO
8806	H9-M/I OTHER AMOUNT CLAIMED SUBMITTED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N48	Claim information does not agree with information received from other insurance carrier.	CO
8807	JE-M/I PERCENTAGE SALES TAX BASIS SUBMITTED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8808	J9-M/I DUR CO-AGENT ID QUALIFIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8809	KE-M/I COUPON TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8810	M1-PATIENT NOT COVERED IN THIS AID CATEGORY	204	This service/equipment/drug is not covered under the patient&#65533;s current benefit plan	N30	Patient ineligible for this service.	CO
8812	M3-HOST PA/MC ERROR	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
8813	M4-PRESCRIPTION/SERVICE REFERENCE NUMBER/TIME LIMIT EXCEEDED	29	The time limit for filing has expired.	N59	Please refer to your provider manual for additional program and provider information.	CO
8814	M5-REQUIRES MANUAL CLAIM	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8815	M6-HOST ELIGIBILITY ERROR	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8816	M7-HOST DRUG FILE ERROR	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8817	M8-HOST PROVIDER FILE ERROR	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8818	ME-M/I COUPON NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8819	MZ-ERROR OVERFLOW	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8820	NE-M/I COUPON VALUE AMOUNT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8821	NN-TRANSACTION REJECTED AT SWITCH OR INTERMEDIARY	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8822	PA-PA EXHAUSTED/NOT RENEWABLE	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.	CO
8823	PB-INVALID TRANSACTION COUNT FOR THIS TRANSACTION CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8824	PC-M/I CLAIM SEGMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8825	PD-M/I CLINICAL SEGMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8826	PE-M/I COB/OTHER PAYMENTS SEGMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N48	Claim information does not agree with information received from other insurance carrier.	CO
8827	PF-M/I COMPOUND SEGMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8828	PG-M/I COUPON SEGMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8829	PH-M/I DUR/PPS SEGMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8830	PJ-M/I INSURANCE SEGMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N245	Incomplete/invalid plan information for other insurance	CO
8831	PK-M/I PATIENT SEGMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N30	Patient ineligible for this service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8832	PM-M/I PHARMACY PROVIDER SEGMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N521	Mismatch between the submitted provider information and the provider information stored in our system.	CO
8833	PN-M/I PRESCRIBER SEGMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N31	Missing/incomplete/invalid prescribing provider identifier.	CO
8834	PP-M/I PRICING SEGMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
8835	PR-M/I PRIOR AUTHORIZATION SEGMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M62	Missing/incomplete/invalid treatment authorization code.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8836	PS-M/I TRANSACTION HEADER SEGMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8837	PT-M/I WORKERS COMPENSATION SEGMENT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8838	PV-NON-MATCHED ASSOCIATED PRESCRIPTION/SERVICE DATE	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N351	Service date outside of the approved treatment plan service dates.	CO
8839	PW-NON-MATCHED EMPLOYER ID	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO
8840	PX-NON-MATCHED OTHER PAYER ID	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N274	Missing/incomplete/invalid other payer other provider identifier.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8841	PY-NON-MATCHED UNIT FORM/ROUTE OF ADMINISTRATION	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N349	The administration method and drug must be reported to adjudicate this service.	CO
8842	PZ-NON-MATCHED UNIT OF MEASURE TO PRODUCT/SERVICE ID	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M53	Missing/incomplete/invalid days or units of service.	CO
8843	P1-ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER NOT FOUND	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	N59	Please refer to your provider manual for additional program and provider information.	CO
8844	P2-CLINICAL INFORMATION COUNTER OUT OF SEQUENCE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8845	P3-COMPOUND INGREDIENT COMPONENT COUNT DOES NOT MATCH NUMBER OF REPETI	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8846	P4-COORDINATION OF BENEFITS/OTHER PAYMENT COUNT DOES NOT MATCH NUMBER	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8847	P5-COUPON EXPIRED	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N59	Please refer to your provider manual for additional program and provider information.	CO
8848	P6-DATE OF SERVICE PRIOR TO DATE OF BIRTH	14	The date of birth follows the date of service.	N329	Missing/incomplete/invalid patient birth date.	CO
8849	P7-DIAGNOSIS CODE COUNT DOES NOT MATCH NUMBER OF REPETITIONS	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8850	P8-DUR/PPS CODE COUNTER OUT OF SEQUENCE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8851	P9-FIELD IS NON-REPEATABLE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8852	RA-PA REVERSAL OUT OF ORDER	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8853	RB-MULTIPLE PARTIALS NOT ALLOWED	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8854	RC-DIFFERENT DRUG ENTITY BETWEEN PARTIAL AND COMPLETION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8855	RD-MISMATCHED CARDHOLDER/GROUP ID-PARTIAL TO COMPLETION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8856	RE-M/I COMPOUND PRODUCT ID QUALIFIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8857	RF- IMPROPER ORDER OF DISPENSING STATUS CODE ON PARTIAL FILL TRANSACTI	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8858	RG-M/I ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER ON COMPLETION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N388	Missing/incomplete/invalid prescription number	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8859	RH-M/I ASSOCIATED PRESCRIPTION/SERVICE DATE ON COMPLETION TRANSACTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N57	Missing/incomplete/invalid prescribing date. (Modified 12/2/04) Related to N304	CO
8860	RJ-ASSOCIATED PARTIAL FILL TRANSACTION NOT ON FILE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8861	RK-PARTIAL FILL TRANSACTION NOT SUPPORTED	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N59	Please refer to your provider manual for additional program and provider information.	CO
8862	RM-COMPLETION TRANSACTION NOT PERMITTED WITH SAME SERVICE DATE AS A PA	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8863	RN-PLAN LIMITS EXCEEDED ON INTENDED PARTIAL FILL VALUES	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8864	RP-OUT OF SEQUENCE P REVERSAL ON PARTIAL FILL TRANSACTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8865	RS-M/I ASSOCIATED PRESCRIPTION/SERVICE DATE ON PARTIAL TRANSACTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N57	Missing/incomplete/invalid prescribing date. (Modified 12/2/04) Related to N304	CO
8866	RT-M/I ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER ON PARTIAL TRA	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N388	Missing/incomplete/invalid prescription number	CO
8867	RU-MANDATORY DATA ELEMENTS MUST OCCUR BEFORE OPTIONAL ELEMENTS IN A SE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8868	R1-OTHER AMOUNT CLAIMED SUBMITTED COUNT DOES NOT MATCH NUMBER OF REPET	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8869	R2-OTHER PAYER REJECT COUNT DOES NOT MATCH NUMBER OF REPETITIONS	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8870	R3-PROCEDURE MODIFIER CODE COUNT DOES NOT MATCH NUMBER OF REPETITIONS	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8871	R4-PROCEDURE MODIFIER CODE INVALID FOR PRODUCT/SERVICE ID	182	Payment adjusted because the procedure modifier was invalid on the date of service	N519	Invalid combination of HCPCS modifiers.	CO
8872	R5-PRODUCT/SERVICE ID MUST BE ZERO WHEN PRODUCT/SERVICE ID QUALIFIER E	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	N59	Please refer to your provider manual for additional program and provider information.	CO
8873	R6-PRODUCT/SERVICE NOT APPROPRIATE FOR THIS LOCATION	5	The procedure code/bill type is inconsistent with the place of service.	N428	Service/procedure not covered when performed in this place of service.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8874	R7-REPEATING SEGMENT NOT ALLOWED IN SAME TRANSACTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8875	R8-SYNTAX ERROR	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8876	R9-VALUE IN GROSS AMOUNT DUE DOES NOT FOLLOW PRICING FORMULAE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or N	N59	Please refer to your provider manual for additional program and provider information.	CO
8877	SE-M/I PROCEDURE MODIFIER CODE COUNT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N519	Invalid combination of HCPCS modifiers.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8878	TE-M/I COMPOUND PRODUCT ID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO
8879	UE-M/I COMPOUND INGREDIENT BASIS OF COST DETERMINATION	90	Ingredient cost adjustment.	N59	Please refer to your provider manual for additional program and provider information.	CO
8880	VE-M/I DIAGNOSIS CODE COUNT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
8881	WE-M/I DIAGNOSIS CODE QUALIFIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	MA63	Missing/incomplete/invalid principal diagnosis.	CO
8882	XE-M/I CLINICAL INFORMATION COUNTER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
8883	ZE-M/I MEASUREMENT DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
8998	INVALID OCCURRENCE CODE	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M45	Missing/incomplete/invalid occurrence code(s). (Modified 12/2/04) Related to N299	CO
8999	CLAIM SET TO SUPERSUSPEND INSTEAD OF FORCE DENY OR FORCE OVERRIDE	133	The disposition of this claim/service is pending further review.	N35	Program integrity/utilization review decision.	PI
9001	COPAY CUTBACK	3	Co-payment Amount	N59	Please refer to your provider manual for additional program and provider information.	PR
9003	NO PAYMENT MADE-TPL/SPENDDOWN IS MORE THAN THE ALLOWED AMOUNT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	M82	Service is not covered when patient is under age 50.	OA
9009	SERVICE DENIED. REIMBURSEMENT FOR INPATIENT HOSP CARE LIMITED TO ONCE	96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO
9090	PROCEDURE NOT COVERED FOR MEMBERS LOCKIN PROV	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95	This provider type/provider specialty may not bill this service.	CO
9200	ORTHODONTIC AUTO ADJUSTMENT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9300	CLMS RESUB - PROV ERROR REWRK	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9301	CLMS RESUB - PROV ERROR NO REW	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9302	CLMS RESUB - FISC AGNT ERR REW	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9303	CLM RESUB - FISC AGNT ERR NORE	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9304	CLM RESUB - REF FILE ERR REWK	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9305	CLM RESUB - REF FILE ERR NORWK	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9306	CLM RESUB/TPL OVRRD PROOF/PRV	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9307	CLEAR FORCE PAID/DENIED EXC CD	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9308	HSD PRICING CHANGE	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9309	DOD CMO DATE OF DEATH NOTIFICATION	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9311	DMA CHANGE IN RECIP AID CATEG	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9312	PROV CLAIM FILING CORRECTION	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9313	PROVIDER PREPAYMENT REV	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9314	CMO SPECIAL DISENROLLMENT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9315	NCCI/MUE ADJUSTMENT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9316	POS PROV FIL CORR/CASLTY INSUR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9317	POS PROV FILE CORR/LEGAL SETT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9318	FISCAL AGENT CLM PROCESS ERROR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9319	HSD SPECIAL WORK ORDER	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9320	HSD PRICE CHANGE	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9321	NEG ADJ PROVIDER FILE CORRECT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9322	NEG PROV FIL CORR/HEALTH INSUR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9323	NEG PROV FILE CORR/CASULTY INS	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9324	NEG PROV FILE CORR/LEGAL SETT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9325	NEG ADJ TPL FISC PROV/HLTH INS	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9326	NEG ADJ TPL FISC PROV/CAS INS	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9327	NEG ADJ TPL FISC PROV/LEG SETT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9328	NEG ADJ TPL FISC PROV/RCP COLL	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9329	NEG ADJ TPL FISC PROV/OTHER	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9330	NEG ADJ SUR RECOVERY FROM PROV	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9331	NEG ADJ FISCAL AGENT CLAIM ERR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9332	NEG ADJ HSD SPECIAL WORK ORDER	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9333	REFUND TPL RECOVERY/MCARE FISC	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9334	REFUND TPLDRUG CASUALTY INS	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9335	REFUND TPLDRUG RCVRY/H INS	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9336	REFUND TPL RECOVERY/HEALTH INS	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9337	REFUND TPL RECOVERY/CASLTY INS	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9338	REFUND TPL RECOVERY/LEGAL SETT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9339	REFUND SUR RECOVERY FROM PROV	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9340	PROVIDER REFUND/CLM OVERPAYMNT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9341	PROV RFND/OVERPAY FISC ERROR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9342	PROV REFUND FOR HEALTH INSUR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9343	PROV REFUND FOR CASUALTY INS	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9344	PROV REFUND FOR LEGAL SETTLMNT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9345	PROV REFUND/TPL RECOVERY/OTHER	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9346	PROV CLAIM FIL CORR/INC RECIP	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9347	PROV CLAIM CORR/CLM FILED ERR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9348	CLM VOID/FISC AGENT PROC ERROR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9349	CLM VD/PD IN ERROR/RCP INCORRE	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9350	CLM VD/PD ERROR/PROV FIL INCOR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9351	CLM VD/PD ERROR/INCORRECT PROV	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9352	CLAIM VOID MEDICARE RECOVERY	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9353	TPL RECOUP FROM PROVIDER	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9354	REFUND - PROVIDER ERROR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9355	REFUND- FISCAL AGENT ERROR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9356	PROV RTRN WARR/PD FOR INC RECP	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9357	PROV RTRN WARR/RCP FILE INCORR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9358	PROV RTRN WARR/PROV FILE INCOR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9359	PROV RTRN WARR/PD BY HLTH INS	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9360	PROV RTRN WARR/PD BY CASUALTY	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9361	PROV RTRN WARR/PD BY LEGAL SET	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9362	P RTRN WARR/FISC AGNT PROCERR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9363	PROV RETURNED WARRANT/OTHER	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9364	STALEDATED WARRANT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9365	PROV RETURN WARR/ INCORR PROV	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9366	MERGE/UNMERGE MEMBER ID	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9367	MEDICARE PYMNT VIA DCH	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9368	MEDICARE PYMNT VIA CNTRCTR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9369	PRVDR PYMT MCRE REIM DCH	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9370	PRVDR PYMT MCRE REIM CNT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9371	CARRIER PYMNT VIA DCH	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9372	CARRIER PYMNT VIA CNT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9373	PROVIDR PYMT CARR REIM DCH	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9374	PRVIDR PYMT CARR REIM CNTR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9375	CSLTY RC PYMT CARR VIA DCH	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9376	CSLTY RC PYMT CARR VIA CNTR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9377	CSLTY RC PYMT PRVD VIA DCH	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9378	CSLTY RC PYMT PRVD VIA CNT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9379	MEMBER PYMT CARR VIA DCH	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9380	MEMBER PYMT CARR VIA CNTR	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9381	MEMBER RC PYMT VIA DCH	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9382	MEMBER RC PYMT VIA CNT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9383	MEMBER PYMT NON CARR RELTD	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9384	WEB ADJUSTMENT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9385	WEB VOID	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9386	PROVIDER ELECTRONIC ADJUSTMENT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9387	PROVIDER ELECTRONIC VOID	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9388	INPAT CLM OUTLIER PAYMENT ADJ	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9389	VOID INTERIM INPAT CLM OVERDUE	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9390	GENERATED VOID/ADJUSTMENT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9391	ENCOUNTER ELECTRONIC ADJUSTMENT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9392	ENCOUNTER ELECTRONIC VOID	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9394	SYS GEN VD/ADJ PRIOR 4/18/04	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9395	PARTIAL CASH ADJUSTMENT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9396	COB ADJUSTMENT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9397	PATIENT LIABILITY ADJUSTMENT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9398	DELETE NET ZERO ADJUSTMENT	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9399	MEMBER HAS MEDICARE COVERAGE	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA
9408	AUTOMATIC TRANSFER ADJUSTMENT - AUDIT 5665	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	MA67	Correction to a prior claim.	OA

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9409	INTERIM CLAIM VOIDED BECAUSE IT HAS NOT FINALIZED OR BEEN REPLACED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	CO
9410	LEGACY C_HDR_ADJ_RSN_CD = 129	129	Payment denied - Prior processing information appears incorrect.	N36	Claim must meet primary payer&#65533;s processing requirements before we can consider payment.	PI
9411	LEGACY C_HDR_ADJ_RSN_CD = 128	128	Newborn's services are covered in the mother's Allowance.	N59	Please refer to your provider manual for additional program and provider information.	CO
9500	THE ADJUSTMENT REQUEST REQUIRES SPECIAL PROCESSING	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA67	Correction to a prior claim.	CO
9501	ADJUSTMENT REVIEWED	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA67	Correction to a prior claim.	CO
9502	ADJUSTMENT REQUEST REVIEWED BY DCH	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA67	Correction to a prior claim.	CO
9503	CLAIM VOIDED CONTACT HP FOR REASON	A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA67	Correction to a prior claim.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9666	INVALID ATTACHMENT TYPE - HDR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO
9670	6TH DIAGNOSIS CODE INVALID FOR MEMBERS SEX	10	The diagnosis is inconsistent with the patient's gender.	N59	Please refer to your provider manual for additional program and provider information.	CO
9671	7TH DIAGNOSIS CODE INVALID FOR MEMBERS SEX	10	The diagnosis is inconsistent with the patient's gender.	N59	Please refer to your provider manual for additional program and provider information.	CO
9672	8TH DIAGNOSIS CODE INVALID FOR MEMBERS SEX	10	The diagnosis is inconsistent with the patient's gender.	N59	Please refer to your provider manual for additional program and provider information.	CO
9673	9TH DIAGNOSIS CODE INVALID FOR MEMBERS SEX	10	The diagnosis is inconsistent with the patient's gender.	N59	Please refer to your provider manual for additional program and provider information.	CO
9674	ADMITTING DIAGNOSIS CODE INVALID FOR MEMBERS SEX	10	The diagnosis is inconsistent with the patient's gender.	N59	Please refer to your provider manual for additional program and provider information.	CO
9675	6TH DIAGNOSIS CODE INVALID FOR MEMBERS SEX	10	The diagnosis is inconsistent with the patient's gender.	N59	Please refer to your provider manual for additional program and provider information.	CO
9676	7TH DIAGNOSIS CODE INVALID FOR MEMBERS SEX	10	The diagnosis is inconsistent with the patient's gender.	N59	Please refer to your provider manual for additional program and provider information.	CO
9677	8TH DIAGNOSIS CODE INVALID FOR MEMBERS SEX	10	The diagnosis is inconsistent with the patient's gender.	N59	Please refer to your provider manual for additional program and provider information.	CO
9678	9TH DIAGNOSIS CODE INVALID FOR MEMBERS SEX	10	The diagnosis is inconsistent with the patient's gender.	N59	Please refer to your provider manual for additional program and provider information.	CO
9679	ADMITTING DIAGNOSIS CODE INVALID FOR MEMBERS SEX	10	The diagnosis is inconsistent with the patient's gender.	N59	Please refer to your provider manual for additional program and provider information.	CO
9800	ENCOUNTER CLAIM CUTBACK	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9900	PRICING ADJUSTMENT - MANUAL PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9906	PRICING ADJUSTMENT - MEDICARE PRICING APPLIED	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	N59	Please refer to your provider manual for additional program and provider information.	OA
9907	TPL AMOUNT APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9909	PRICING ADJUSTMENT - 50% OF AMOUNT BILLED APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9910	PHARMACY DISPENSING FEE APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9911	PRICING ADJUSTMENT - LONG TERM CARE PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9912	PRICING ADJUSTMENT - AMBULATORY SURGERY PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9914	PRICING ADJUSTMENT - REVENUE CODE RATE PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9915	PRICING ADJUSTMENT - MEDICARE PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9916	PRICING ADJUSTMENT - PROVIDER RATE PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9919	PRICING ADJUSTMENT - ZERO PRICED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9920	PRICING ADJUSTMENT - RBRVS PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9921	PRICING ADJUSTMENT - PA PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9922	PATIENT LIABILITY DEDUCTED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9923	FIRST DAY PATIENT LIABILITY APPLIED	178	Payment adjusted because the patient has not met the required spend down requirements.	N59	Please refer to your provider manual for additional program and provider information.	PR
9926	CLAIM HAS CUTBACK AMOUNT	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9928	PRICING ADJUSTMENT - PER DIEM PRICING APPLIED	147	Provider contracted/negotiated rate expired or not on file.	N59	Please refer to your provider manual for additional program and provider information.	CO
9930	MULTIPLE SURGERY REDUCTION APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9931	INPATIENT CROSSOVER CLAIM HAS BEEN PAID	13	The date of death precedes the date of service.	N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	CO
9932	PER DIEM PLUS PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9933	PATIENT RESPONSIBILITY ADJUSTMENT-LTC PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9934	PRICING ADJUSTMENT - DIALYSIS TECHNICAL COMPONENT PRORATING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9935	PRICING ADJUSTMENT - MAXIMUM FLAT FEE PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9938	PRICING ADJUSTMENT - PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9939	DATE OF DEATH CUTBACK	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9940	DATE OF DISCHARGE CUTBACK	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9941	PRICING ADJUSTMENT - ANESTHESIA PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9944	PRICING ADJUSTMENT - HOSPICE SNF PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9945	PRICING ADJUSTMENT - ANESTHESIA UNIT CONVERSION	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9946	PRICING ADJUSTMENT - EPIDURAL PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9947	PRICING ADJUSTMENT - ENDOSCOPY PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9948	DISCOUNT AMOUNT APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9949	PRICING ADJUSTMENT - BED HOLD/LEAVE DAY CUTBACK	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9950	UNIT CUTBACK APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9951	PRICING ADJUSTMENT - PPS UNIT CUTBACK	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9952	INPATIENT CAP REDUCTION APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9953	PATIENT RESPONSIBILITY APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9954	ESTIMATED AMOUNT DUE APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9955	PRICING ADJUSTMENT - CALCULATED ALLOWED AMOUNT GREATER THAN BILLED AMO	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9956	PRICING ADJUSTMENT - BENEFIT ADJUSTMENT FACTOR (BAF) APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9957	PRICING ADJUSTMENT - PPS PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9958	PRICING ADJUSTMENT - UNLISTED/UNCLASSIFIED INJECTABLE DRUG PRICING APP	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9959	MEDICARE PAID AMT EXCEEDS MEDICAID MAX ALLOWED AMT	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9960	RESPITE CARE PRICING CUTBACK	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9961	PRICING ADJUSTMENT - ASC GROUP 6 CUTBACK	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9962	PRICING ADJUSTMENT - EPO CROSSOVER UNITS CONVERTED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9963	PRICING ADJUSTMENT - PRICED AT 90% MEDICARE RATE OR ALLOWED AMOUNT	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9964	PRICING ADJUSTMENT - COINSURANCE PLUS DEDUCTIBLE PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9965	ZERO PAY FOR TYPE OF BILL 110 CLAIMS	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N524	Based on policy this payment constitutes payment in full.	CO
9966	PRICING ADJUSTMENT - SEMI-PRIVATE ROOM RATE	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9967	DI - DRG WEIGHT BASE PAYMENT APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9968	PRICING ADJUSTMENT - DRG WEIGHT BASE PAYMENT	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9969	CI - CCR BASE PAYMENT APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9970	PRICING ADJUSTMENT - CCR BASE PAYMENT	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9971	PRICING ADJUSTMENT - CAP/GME ADD-ON	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9972	ST- SHORT STAY PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9973	TR- TRANSFER PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9974	DO - CLAIM IS OUTLIER ELIGIBLE	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9975	IO - OUTLIER PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9976	PRICING ADJUSTMENT - OUTLIER SUPPLEMENTAL PAYMENT	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9977	PRICING ADJUSTMENT - NEWBORN ADD-ON	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9978	PRICING ADJUSTMENT - OUTLIER DISALLOW	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9979	PRICING ADJUSTMENT - ALLOWED AMOUNT REDUCED BY THE COST SHARE AMOUNT	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9980	ACA PROVIDER RATE INCREASE - PRICING ADJUSTMENT	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9981	PRICING ADJUSTMENT - PROVIDER PERCENT OF CHARGE PRICING APPLIED	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9982	PRICING ADJUSTMENT - PAID AMOUNT REDUCED BY THE STATE SHARE AMOUNT	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9983	PRICING ADJUSTMENT - UNUSUAL PROCEDURE ADD-ON (PERCENTAGE)	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9984	PRICING ADJUSTMENT - UNUSUAL PROCEDURE ADD-ON (FLAT AMOUNT)	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9985	PRICING ADJUSTMENT - ASSISTANT SURGEON CUTBACK	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9986	PRICING ADJUSTMENT - TWO SURGEONS CUTBACK	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9987	PRICING ADJUSTMENT - RETURN TRIP TO THE OPERATING ROOM CUTBACK	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9988	PRICING ADJUSTMENT - MULTIPLE TOOTH EXTRACTION CUTBACK	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9989	PRICING ADJUSTMENT - BILATERAL PROCEDURE ADD-ON	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9990	PRICING ADJUSTMENT - NON COVERED DETAIL TOTAL	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9992	15% PEACH CARE DRG ADD-ON AMOUNT	172	Payment is adjusted when performed/billed by a provider of this specialty	N59	Please refer to your provider manual for additional program and provider information.	CO

EOB	EOB Description	Adj Rsn Code	Adj Rsn Description	Remark Code	Remark Description	Group Code
9993	FLAT FEE EMERGENCY PRICING APPLIED AFTER REVIEW	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N59	Please refer to your provider manual for additional program and provider information.	CO
9995	PRICING ADJUSTMENT - HOSPITAL RATE ADD-ON	172	Payment is adjusted when performed/billed by a provider of this specialty	N59	Please refer to your provider manual for additional program and provider information.	CO
9996	PRICING ADJUSTMENT - HOSPITAL RATE ADD-ON TO IP CAP	172	Payment is adjusted when performed/billed by a provider of this specialty	N59	Please refer to your provider manual for additional program and provider information.	CO
9997	PRICING ADJUSTMENT - HOSPITAL RATE ADD-ON TO ER FLAT FEE	172	Payment is adjusted when performed/billed by a provider of this specialty	N59	Please refer to your provider manual for additional program and provider information.	CO
9998	CLAIM IS PENDING. CLAIM WILL APPEAR AS PAID OR DENIED ON A FUTURE REMI	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co	N59	Please refer to your provider manual for additional program and provider information.	CO