FOR Code	Description
0001	PLEASE VERIFY THE DATES OF SERVICE. HEADER FROM DATE OF SERVICE IS MISSING OR INVALID.
0002	THE ADMITTING DATE OF SERVICE IS MISSING/INVALID OR LATER THAN THE FROM DATE OF SERVICE.
-	PLEASE VERIFY THE DATES OF SERVICE. THE TO DATE OF SERVICE IS INVALID, MISSING, FUTURE DATE OR LESS THAN THE FROM DATE
0004	MEDICARE PAID DATE IS MISSING OR INVALID.
0005	EACH PROVIDER IS LIMITED TO BILLING ONLY 1 OF THE FOLLOWING PROCEDURES(HOSP ADM, ER VIS, CONSULT, OV)/MEMBER/SAME
0006	THE DISCHARGE DATE IS MISSING OR INVALID.
0007	TOTAL DAYS DO NOT EQUAL THE DIFFERENCE BETWEEN FROM AND TO DATES.
0008	CLAIM DENIED REQUEST FOR PAYMENT WAS REC'D BEYOND MEDICAID FILING LMT CLAIMS MUST BE FILED WITHIN 1 YR OF THE DOS
0009	CLAIM DENIED. RESEARCH DATA UNAVAILABLE TO PROCESS CLAIM PLEASE RESUBMIT CLAIMWITH ITEMIZED BILL. SUMMARY
0010	CLAIM DENIED. PLEASE RESUBMIT CLAIM WITH ANESTHESIA REPORT.
-	NUMBER OF UNITS BILLED IS NOT EQUAL TO DATE SPAN
0012	ONLY ONE UNIT IS PAYABLE PER DATE OF SERVICE FOR THIS SERVICE. UNITS OF SERVICE CHANGED TO ONE.
0013	DISCHARGE DATE IS PRIOR TO THROUGH DATE OF SERVICE.
0014	CODE INDICATING SUPERVISING PROFESSIONAL IS MISSING/INVALID.
0015	CLAIM/DETAIL DETAIL DENIED. PROCEDURE IS LIMITED TO THE FOLLOWING CONDITIONS - CONGENITAL, HEREDITARY OR DRUG
0016	CLAIM/DETAIL DENIED. PROCEDURE IS LIMITED TO TRAUMA RELATED INJURIES.
0017	LONG TERM CARE DAYS BILLED IS GREATER THAN THE NUMBER OF DAYS IN BILLING MONTH.
0018	CLAIM DENIED. ACCOMMODATION/ANCILLARY CODE MISSING OR INVALID.
0019	CLAIM/DETAIL DENIED. PROCEDURE/NDC MISSING/INVALID.
0020	MEDICARE DOCUMENTATION NOT ATTACHED.
0021	CLAIM DENIED. PHYSICIAN ON REPORT AND PHYSICIAN BILLING DO NOT MATCH.
0022	COVERED DAYS ARE NOT EQUAL TO ACCOMMODATION UNITS.
0023	CLAIM DENIED. NO PHYSICIAN PATIENT CONTACT.
0024	THE DETAIL BILLED AMOUNT IS MISSING OR INVALID.
0025	CLAIM SUBMITTED FOR INFORMATIONAL PURPOSE ONLY. NO PAYMENT IS TO BE MADE.
0026	CLAIM DENIED. LONG TERM CARE SUPPLEMENTAL BILLING MUST BE SUBMITTED AS AN ADJUSTMENT.
0027	CLAIM DENIED. RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM.
0028	CLAIM/DETAIL DENIED. DATA ILLEGIBLE. PLEASE RESUBMIT.
0029	CLAIM REQUIRES DOCUMENTATION. PLEASE RESUBMIT ON PAPER. DEPENDENT ON SPECIFICPROCEDURE CODE AND CRITERIA SET
0030	CLAIM/DETAIL DENIED. DETAIL NUMBER OF SERVICES MISSING.
0031	CLAIM DENIED. LEVEL OF CARE MISSING. PLEASE CORRECT AND RESUBMIT.
0032	CLAIM DENIED. UNIT OF MEASURE INVALID. DOES NOT MATCH NDC UNIT OF MEASURE.
0033	NUMBER OF UNITS BILLED LESS THAN 30 FOR INSULIN SYRINGES
0034	DENIED BY MEDICARE.
0035	DETAIL DENIED. THIS SERVICE NOT PAYABLE ON THIS DATE OF SERVICE
0036	CLAIM DENIED. ONLY 1 DATE OF SERVICE ALLOWED PER CLAIM FORM.
0037	MODEL WAIVER 1 MEMBER LIMITED TO 24 HOURS OF NURSING SERVICES PER DATE OF SERVICE.
0038	CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR PLACE OF SERVICE.
0039	THIS PROCEDURE CODE IS LIMITED TO TWO UNITS OF SERVICE PER DATE OF SERVICE.
0040	CLAIM/DETAIL DENIED. TYPE OF BILL INVALID OR MISSING.
0041	DRUG MANAGEMENT AND MEDICAL PSYCHOTHERAPY NOT ALLOWED FOR SAME DATE OF SERVICE, PROVIDER, MEMBER.
0042	CLAIM DENIED. COINSURANCE AND/OR DEDUCTIBLE GREATER ON CLAIM THAN EOMB.
0043	CLAIM DENIED. VOUCHER NUMBER MISSING OR INVALID.
0044	CLAIM DETAIL DENIED. REVENUE CODE MISSING OR INVALID.
0045	TYPE OF BILL INVALID FOR PROVIDER TYPE.
0046	CLAIM DENIED. HCPCS CODE BILLED INVALID/OBSOLETE. RESUBMIT WITH CORRECT CODE.
0047	PROFESSIONAL COMPONENT BILLED. CLAIM MANUALLY PRICED TO MAXIMUM ALLOWABLE
0048	CLAIM DENIED. MEDICARE PAID PATIENT, REFER TO DMS PROVIDER SERVICES MAN UAL AND RESUBMIT.
0049	CLAIM/DETAIL DENIED. MEDICARE PAID AMOUNT GREATER THAN OR EQUAL TO TOTAL BILLED AMOUNT.
0050	CLAIM DENIED. PLEASE CORRECT COVERED DAYS FIELD AND RESUBMIT
0051	PATIENT CONDITION/STATUS CODE MISSING, INVALID, OR INVALID FOR TYPE OF BILL.
0052	ERROR ON CLAIM RELATED TO DOLLAR AMOUNTS -CLAIM IN PROCESS.
0053	CLAIM/DENIED. NET BILLED NOT EQUAL TO TOTAL BILLED MINUS OTHER INSURANCE.
0054	CLAIM DENIED. OTHER INSURANCE AMOUNT MUST BE MANUALLY COMPUTED FOR THIS CLAIM
0055	CLAIM DENIED TOTAL DETAIL CHARGES NOT EQUAL TO TOTAL BILLED.

EOB Code	Description
	CLAIM/DETAIL DENIED. ASSISTANT SURGEON SERVICES NOT PAYABLE FOR A VAGINAL DELIVERY.
	INVALID TYPE OF BILL FOR CORF/ORF PROVIDER SPECIALTY.
	CLAIM/DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL.
	CLAIM/DETAIL DENIED. NET BILLED CHARGE MISSING OR INVALID.
	CLAIM DENIED. LOCATION CODE INVALID.
0061	PAID IN FULL BY MEDICAID.
0062	CLAIM DENIED. THE HOUR OF ADMISSION IS MISSING OR INVALID.
0063	CLAIM DENIED. LONG TERM CARE FACILITY NUMBER MUST BE ENTERED IN FACILITY ID FIELD.
0064	THE TIME OF PICK UP IS BEFORE THE TIME OF CALL IN.
0065	DESTINATION CODE IS MISSING/INVALID.
	PRO STICKER/INDICATOR MISSING OR INVALID
	FAMILY PLANNING INDICATOR INVALID.
0068	AM/PM PICK-UP INDICATOR MISSING OR INVALID.
0069	TIME OF CALL IN MISSING/INVALID.
	TIME OF PICK UP IS MISSING OR INVALID.
	DESTINATION CODE MISSING/INVALID.
	PICK-UP LOCATION CODE MISSING OR INVALID.
0073	REFERRED TO 'OTHER' CODE INVALID.
0074	ANCILLARY CHARGES NOT PAYABLE IN CONJUNCTION WITH VENTILATOR OR BRAIN INJURY PROGRAM REIMBURSEMENT.
0075	CLAIM DENIED. QUANTITY DOES NOT MATCH PACKAGE SIZE OR A MULTIPLE OF THE PACKAGE SIZE.
	OTHER MEANS OF TRANSPORTATION CODE MISSING OR INVALID.
0077	CLAIM DETAIL/DENIED. TIME OF CALL-IN AM/PM INDICATOR MISSING
	CLAIM/DETAIL DENIED. BASE RATE OR RATE PER MILE MISSING OR INVALID.
0079	CLAIM/DETAIL DENIED. DETAIL TOTAL BILL NOT=(RATE PER MILE X EXTRA MILES).
0080	PROVIDER TYPE INVALID FOR CATEGORY OF SERVICE.
0081	CLAIM DENIED. NUMBER OF PERSONS SHARING RIDE INVALID.
0082	CLAIM DENIED. TYPE OF TRIP MISSING OR INVALID.
0083	CLAIM DENIED. SECONDARY SURGERY DATE MISSING/INVALID
0084	CLAIM DENIED. PRIMARY SURGERY DATE MISSING/INVALID.
0085	CLAIM DENIED/INVALID LINE ITEM PROVIDER LICENSE NUMBER
0086	PROVIDER INELIGIBLE FOR DATE OF SERVICE. PLEASE CONTACT PROVIDER ENROLL MENT AT (877) 838-5085 OR (877) 838-5085 FOR
0087	CLAIM DENIED. TO DATE OF SERVICE EQUAL TO DATE OF RECEIPT.
0088	CLAIM DENIED. CLAIM INVOICE DATE MISSING/INVALID.
0089	DETAIL CHARGE MISSING OR INVALID.
0090	CLAIM DENIED. EPSDT DISPOSITION CODE MISSING OR INVALID.
0091	CLAIM DENIED. YOU MUST INDICATE IN BLOCK 15 IF THIS WAS A PARTIAL, COMPLETE, OR COMPLETION OF A PARTIAL EXAM FOR
0092	THIS SERVICE DENIED. PLEASE RESUBMIT CLAIM WITH COPY OF PATHOLOGY REPORT.
0093	THIS SERVICE DENIED. PLEASE RESUBMIT WITH HISTORY AND PHYSICAL NOTES.
0094	PHYSICIAN SIGNATURE AND DATE ON CONSENT FORM MUST BE ON OR AFTER DATE OF SERVICE
0095	CONSENT FORM IS ILLEGIBLE. RESUBMIT LEGIBLE COPY WITH CLAIM
0096	MEMBER'S SIGNATURE ON CONSENT FORM MUST BE ON OR BEFORE DATE OF SERVICE.
0097	DATES OF SERVICE ON CLAIM AND CONSENT FORM DISAGREE.
0098	MEMBER MUST BE 21 TO LEGALLY SIGN THE FEDERAL STERILIZATION CONSENT FORM.
0099	PERSON OBTAINING CONSENT MUST SIGN ON OR AFTER DATE OF MEMBER SIGNATURE BUT PRIOR TO THE STERILIZATION
0100	DETAIL FROM DATE OF SERVICE MISSING OR INVALID.
0101	DETAIL TO DATE OF SERVICE MISSING OR INVALID.
0102	CLAIM DETAIL DENIED. LATE BILLING DATE OF SERVICE PAST ONE YEAR FILING LIMIT. VERIFIES THAT EACH DETAIL OF A CLAIM IS
0103	MISSING OR ALTERED MEMBER SIGNATURE OR DATE ON CONSENT FORM IS NOT ACCEPTABLE.CLAIM NOT PAYABLE BY MEDICAID.
0105	CLAIM DENIED. CLAIM SUBMITTED FOR HEARING AID AND HEARING AID PARTS SHALL REFLECT THE ACTUAL LABORATORY COST OF
0106	INCLUDED IN FLAT FEE FOR MAJOR PROCEDURES.
0107	INCLUDED IN REIMBURSEMENT FOR OFFICE VISIT
0108	CONSENT FORM IS INCOMPLETE
0109	INCORDECT CTERLIZATION CONCENT FORM LICED
0103	INCORRECT STERLIZATION CONSENT FORM USED.
	CLAIM SUSPENDED FOR REVIEW.

10.112 CLAMD BENIED. DOCUMENTATION ATTACHED WAS INSUFFICIENT TO WAIVE ONE YEAR FILINGLIMITATION. PLASE CALL PROVIDER 10.113 CLAMD DENIED. REQUIRED DOCUMENTATION WAS NOT COMPLETED PRIOR TO STERILIZATION PROCEDURE. CLAIM NOT PAYABLE BY 10.114 PROVIDER A PROVIDED TO RECEIVABLE. 10.115 PAYABLE PAY 10.115 PAYABLE PAY 10.116 DOCUMENTATION OF MIDICAL INFERSITY REQUIRED. CONSULT YOUR PROVIDER MANUAL. 10.117 CLAIM DENIED. THIS TYPE OF BILL NOT VALID FOR DORS RELATED CLAIM. 10.118 OUR RECORDS INDICATE PADID IN FULL BY MEDICARE. 10.119 NOT COVERED UNDER THE PROGRAM EXCEPT UNDER RESOT. 10.119 NOT COVERED UNDER THE PROGRAM EXCEPT UNDER RESOT. 10.120 LAB PROCEDURE ON THE PROGRAM EXCEPT UNDER RESOT. 10.121 HIS SERVICE IS NOT PAYABLE FOR A OMB-ONLY MEMBER. 10.122 THIS SERVICE WAS NOT APPROVED BY MEDICARE. 10.123 THIS SERVICE WAS NOT APPROVED BY MEDICARE. 10.124 PLASE PROVIDED HIS CLAIM MAY NOT SPAN THE MEMBER'S 1ST BIRTHDAY, PLEASE REFER TO THE BILLING INSTRUCTIONS IN YOUR 10.125 PROCEDURE CODES IS NINAL MOST A CONTROLLED. 10.126 PROCEDURE CODES IS NINAL POSTAL SERVICE SERVICE TO MEDICAID WITH A COPY OF THE MEDICARE 10.127 THIS SERVICE SHOW SHOW THE ADDITION OF THE MEDICARE 10.128 PROVIDED WAS DEVELOPED. 10.129 THE TOOTH HUMBER IS NISSING OR INVALID. 10.129 PROCEDURE CODES IS NISSING OR INVALID. 10.219 PROCEDURE CODES IS NISSING OR INVALID. 10.219 PROCEDURE CODES IN MISSING OR INVALID. 10.220 PROCEDURE CODES IS NISSING OR INVALID. 10.231 PROVIDED OR HUMBER IS NISSING OR INVALID. 10.241 PROCEDURE CODES INVALID OR OTHER THAN ANTERIOR TOOTH NUMBERS. 10.2420 PROCEDURE SECULATION OF THE MEMBER. 10.2420 PROCEDURE CODES ON THE BOALLY LUMINATION FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED. 10.233 PROVIDED ON THE PROVIDER OF THIS PROCEDURE CODE HAS BEEN EXCEEDED. 10.234 PROCEDURE ON THE PROVIDER OF THIS PROVIDER PROVIDER OF THIS PROVIDER PROVIDER ON THIS PR	EOB Code	Description
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DATES OF SERVICE FOR THIS CLAIM TYPE MUST ALL BE FROM THE SAME MONTH. 10199 CLAIM DETAIL DENIED. REVENUE CODE 360 MUST BE BILLED WITH A SURGICAL PROCEDURE CODE (01000 THROUGH 69999). 10200 CLAIM/DETAIL DENIED. PROVIDER ON REVIEW FOR THIS DIAGNOSIS. 10201 BILLING PROVIDER/NPI NUMBER IS MISSING. 10202 INDIVIDUAL/CLINIC PROVIDER/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE. 10203 CLAIM/DETAIL DENIED. PROCEDURE CODE MODIFIER AG OR TYPE OF SERVICE 7 OR B NOT ALLOWED FOR DATES OF SERVICE AFTER 10204 INVALID DIAGNOSIS CODE. CONTACT THE DEPARTMENT FOR MEDICAID SERVICES. 10205 DIAGNOSIS CODE INVALID FOR PROVIDER TYPE 10206 CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE. 10207 DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE. 10208 THIS PROCEDURE IS NOT COVERED FOR THIS DIAGNOSIS 10209 CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE CODES BEGINING WITH 0. 10210 CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW. 10211 THIRD DIAGNOSIS IS THIS DIAGNOSIS INDICATOR INVALID. 10212 CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. 10213 THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. 10214 CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. 10215 CLAIM DENIED - AGE RESTRICTION FOR COVERED DIAGNOSIS 10216 CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. 10217 THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. 10218 CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. 10217 THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE. 10217 THE FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. 10218 FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. 10219 FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX.	0196	THE BILLED DIAGNOSIS IS ON REVIEW.
CLAIM DETAIL DENIED. REVENUE CODE 360 MUST BE BILLED WITH A SURGICAL PROCEDURE CODE (01000 THROUGH 69999). CLAIM/DETAIL DENIED. PROVIDER ON REVIEW FOR THIS DIAGNOSIS. DIAGNOSIS. DILLING PROVIDER/NPI NUMBER IS MISSING. BILLING PROVIDER/NPI NUMBER IS MISSING. CLAIM/DETAIL DENIED. PROCEDURE CODE MODIFIER AG OR TYPE OF SERVICE 7 OR B NOT ALLOWED FOR DATES OF SERVICE AFTER INVALID DIAGNOSIS CODE. CONTACT THE DEPARTMENT FOR MEDICAID SERVICES. DIAGNOSIS CODE INVALID FOR PROVIDER TYPE CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE. DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE. CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE CODES BEGINING WITH 0. CLAIM/DETAIL DENIED. HEADER DIAGNOSIS ON REVIEW. DETAIL DIAGNOSIS CODE IS NOT ON FILE. CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM/DETAIL DENIED. THIRD DIAGNOSIS INDICATOR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM/DETAIL DENIED. THIRD DIAGNOSIS INDICATOR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. CLAIM/DETAIL DENIED. THIRD DIAGNOSIS INDICATOR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. THE FOURTH DIAGNOSIS IS INVALID. FOR MEMBER'S SEX. THE FOURTH DIAGNOSIS IS INVALID. POR MEMBER'S SEX. THE FOURTH HEADER DIAGNOSIS ON REVIEW.	0197	CLAIM/DETAIL DENIED. ROOT CANAL THERAPY LIMITED TO PERMANENT TEETH,
CLAIM/DETAIL DENIED. PROVIDER ON REVIEW FOR THIS DIAGNOSIS. DILLING PROVIDER/NPI NUMBER IS MISSING. DIAGNOSIS CODE INDIVIDUAL/CLINIC PROVIDER/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE. CLAIM/DETAIL DENIED. PROVIDER/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE. CLAIM/DETAIL DENIED. PROVIDER /NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE. DIAGNOSIS CODE INVALID FOR PROVIDER THE DEPARTMENT FOR MEDICAID SERVICES. DIAGNOSIS CODE INVALID FOR PROVIDER TYPE CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE. DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE. THIS PROCEDURE IS NOT COVERED FOR THIS DIAGNOSIS CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE CODES BEGINING WITH 0. CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW. THIRD DIAGNOSIS CODE IS NOT ON FILE. CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0198	DATES OF SERVICE FOR THIS CLAIM TYPE MUST ALL BE FROM THE SAME MONTH.
BILLING PROVIDER/NPI NUMBER IS MISSING. INDIVIDUAL/CLINIC PROVIDER/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE. CLAIM/DETAIL DENIED. PROCEDURE CODE MODIFIER AG OR TYPE OF SERVICE 7 OR B NOT ALLOWED FOR DATES OF SERVICE AFTER INVALID DIAGNOSIS CODE. CONTACT THE DEPARTMENT FOR MEDICAID SERVICES. DIAGNOSIS CODE INVALID FOR PROVIDER TYPE CLAIM DENIED. RENDERING PROVIDER TYPE CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE. DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE. THIS PROCEDURE IS NOT COVERED FOR THIS DIAGNOSIS CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE CODES BEGINING WITH 0. CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW. CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. THIRD DIAGNOSIS CODE IS NOT ON FILE. CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM/DETAIL DENIED. AGE RESTRICTION FOR COVERED DIAGNOSIS CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER'S SEX. THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER'S SEX. THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER'S SEX. SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0199	CLAIM DETAIL DENIED. REVENUE CODE 360 MUST BE BILLED WITH A SURGICAL PROCEDURE CODE (01000 THROUGH 69999).
INDIVIDUAL/CLINIC PROVIDER/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE. CLAIM/DETAIL DENIED. PROCEDURE CODE MODIFIER AG OR TYPE OF SERVICE 7 OR B NOT ALLOWED FOR DATES OF SERVICE AFTER D204 INVALID DIAGNOSIS CODE. CONTACT THE DEPARTMENT FOR MEDICAID SERVICES. D1AGNOSIS CODE INVALID FOR PROVIDER TYPE CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE. DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE. D208 THIS PROCEDURE IS NOT COVERED FOR THIS DIAGNOSIS CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE CODES BEGINING WITH 0. CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW. D11 THIRD DIAGNOSIS CODE IS NOT ON FILE. CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. D12 CLAIM/DETAIL DENIED. BETAIL DIAGNOSIS INDICATOR INVALID. D13 THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM/DETAIL DENIED. AGE RESTRICTION FOR COVERED DIAGNOSIS CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. THE FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. THE FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. D17 THE FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. D17 THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER'S AGE. D18 FOURTH HEADER DIAGNOSIS ON REVIEW. SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0200	CLAIM/DETAIL DENIED. PROVIDER ON REVIEW FOR THIS DIAGNOSIS.
CLAIM/DETAIL DENIED. PROCEDURE CODE MODIFIER AG OR TYPE OF SERVICE 7 OR B NOT ALLOWED FOR DATES OF SERVICE AFTER INVALID DIAGNOSIS CODE. CONTACT THE DEPARTMENT FOR MEDICAID SERVICES. DIAGNOSIS CODE INVALID FOR PROVIDER TYPE CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE. DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE. DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE. DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE. CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE CODES BEGINING WITH 0. CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW. DETAIL DIAGNOSIS CODE IS NOT ON FILE. CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER'S SEX. THE FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0201	BILLING PROVIDER/NPI NUMBER IS MISSING.
INVALID DIAGNOSIS CODE. CONTACT THE DEPARTMENT FOR MEDICAID SERVICES. DIAGNOSIS CODE INVALID FOR PROVIDER TYPE CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE. DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE. DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE. CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE CODES BEGINING WITH 0. CLAIM/DETAIL DENIED. HIRD HEADER DIAGNOSIS ON REVIEW. THIRD DIAGNOSIS CODE IS NOT ON FILE. CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE. FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0202	INDIVIDUAL/CLINIC PROVIDER/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE.
DIAGNOSIS CODE INVALID FOR PROVIDER TYPE CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE. DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE. THIS PROCEDURE IS NOT COVERED FOR THIS DIAGNOSIS CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE CODES BEGINING WITH 0. CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW. CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW. CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM DENIED - AGE RESTRICTION FOR COVERED DIAGNOSIS CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE. CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. CO217 THE FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. CO218 FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. CO219 FOURTH HEADER DIAGNOSIS ON REVIEW. CO220 SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0203	CLAIM/DETAIL DENIED. PROCEDURE CODE MODIFIER AG OR TYPE OF SERVICE 7 OR B NOT ALLOWED FOR DATES OF SERVICE AFTER
CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE. DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE. THIS PROCEDURE IS NOT COVERED FOR THIS DIAGNOSIS CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE CODES BEGINING WITH 0. CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW. CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW. CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE. CLAIM/DETAIL DENIED. THIRD DIAGNOSIS ON REVIEW. SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0204	INVALID DIAGNOSIS CODE. CONTACT THE DEPARTMENT FOR MEDICAID SERVICES.
DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE. DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE. DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE. DETAIL DIAGNOSIS INVALID FOR THIS DIAGNOSIS CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE CODES BEGINING WITH 0. DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW. DETAIL DIAGNOSIS CODE IS NOT ON FILE. CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE. DETAIL DIAGNOSIS IS INVALID FOR MEMBER'S SEX. DETAIL DIAGNOSIS ON REVIEW. SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0205	DIAGNOSIS CODE INVALID FOR PROVIDER TYPE
THIS PROCEDURE IS NOT COVERED FOR THIS DIAGNOSIS CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE CODES BEGINING WITH 0. CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW. THIRD DIAGNOSIS CODE IS NOT ON FILE. CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM DENIED - AGE RESTRICTION FOR COVERED DIAGNOSIS CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE. THE FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0206	CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE.
CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE CODES BEGINING WITH 0. CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW. THIRD DIAGNOSIS CODE IS NOT ON FILE. CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM DENIED - AGE RESTRICTION FOR COVERED DIAGNOSIS CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE. FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. FOURTH HEADER DIAGNOSIS ON REVIEW. SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0207	DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE.
CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW. 10211 THIRD DIAGNOSIS CODE IS NOT ON FILE. 10212 CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. 10213 THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. 10214 CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. 10215 CLAIM DENIED - AGE RESTRICTION FOR COVERED DIAGNOSIS 10216 CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. 10217 THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE. 10218 FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. 10219 FOURTH HEADER DIAGNOSIS ON REVIEW. 10220 SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0208	THIS PROCEDURE IS NOT COVERED FOR THIS DIAGNOSIS
THIRD DIAGNOSIS CODE IS NOT ON FILE. CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM DENIED - AGE RESTRICTION FOR COVERED DIAGNOSIS CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER' AGE. THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE. FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. POURTH HEADER DIAGNOSIS ON REVIEW. SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0209	CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE CODES BEGINING WITH 0.
CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM DENIED - AGE RESTRICTION FOR COVERED DIAGNOSIS CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE. FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. CLAIM/DETAIL DENIED. THIRD DIAGNOSIS SEX. SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0210	CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW.
THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM DENIED - AGE RESTRICTION FOR COVERED DIAGNOSIS CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE. FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. DETAIL OF THE FOURTH DIAGNOSIS ON REVIEW. SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0211	THIRD DIAGNOSIS CODE IS NOT ON FILE.
CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. CLAIM DENIED - AGE RESTRICTION FOR COVERED DIAGNOSIS CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE. FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. FOURTH HEADER DIAGNOSIS ON REVIEW. SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0212	CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID.
CLAIM DENIED - AGE RESTRICTION FOR COVERED DIAGNOSIS CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE. FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. FOURTH HEADER DIAGNOSIS ON REVIEW. SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0213	THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM.
0216 CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. 0217 THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE. 0218 FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. 0219 FOURTH HEADER DIAGNOSIS ON REVIEW. 0220 SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0214	CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW.
THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE. FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. FOURTH HEADER DIAGNOSIS ON REVIEW. SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0215	CLAIM DENIED - AGE RESTRICTION FOR COVERED DIAGNOSIS
0218 FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. 0219 FOURTH HEADER DIAGNOSIS ON REVIEW. 0220 SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0216	
0219 FOURTH HEADER DIAGNOSIS ON REVIEW. 0220 SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0217	THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE.
0220 SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	0218	FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX.
	0219	FOURTH HEADER DIAGNOSIS ON REVIEW.
0221 THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE.	0220	SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.
	0221	THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE.

EOR Code	Description
0222	THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE
-	THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE
	CLAIM DENIED. MISSING OR INVALID DIAGNOSIS CODE.
0224	
	NO HISTORY MATCH FOUND, PLEASE RESUBMIT.
0226	CANNOT BEPROCESSED ON THIS CLAIM FORM.
0227	CLAIM OVERLAPS YOUR FISCAL YEAR END.
0228	THE PROVIDER IS NOT ELIGIBLE FOR DATE OF SERVICE.
	BILLING PROVIDER NUMBER INVALID OR NOT ON PROVIDER FILE.
0230	THE CLINIC IS NOT ELIGIBLE FOR THE CLAIM DATES OF SERVICE.
0231	CLAIM/DETAIL DENIED. BILLING PROVIDER NAME DOES NOT MATCH THE NAME ON PROVIDER FILE.
0232	CLAIM/DETAIL DENIED. PROVIDER IS ON PREPAYMENT REVIEW.
0233	UPIN MISSING OR INVALID.
0234	CLAIM/DETAIL DENIED. REFERRING PROVIDER FLAG SET TO SUSPEND FOR REVIEW.
	SERVICE NOT PROVIDED UNDER THE MEDICAID PROGRAM.
0236	PERFORMING PROVIDER NOT ASSOCIATED WITH THE BILLING PROVIDER.
0237	CLAIM DENIED. CLINIC PROVIDER NUMBER NOT ON FILE.
0238	CLAIM DENIED. BILLING PHYSICIAN/PROVIDER NOT LISTED AS MEMBER OF CLINIC.
0239	DETAIL PROVIDER NUMBER INVALID OR NOT ON FILE.
0240	MODIFIER 26 OR 50 CANNOT BE BILLED WITH THIS PROCEDURE CODE.
0241	PENDING CONFIRMATION OF PROVIDER ELIGIBILITY.
0242	NO LEVEL 2 PRICING RECORD FOUND FOR MODIFIERS TC OR 26.
0243	PROCEDURE CODE Y2870 INVALID FOR DATES OF SERVICE 10/15/94 AND AFTER FOR THIS PROVIDER TYPE.
0244	PROVIDER HAS NOT MET ALL REQUIREMENTS FOR BILLING OTHER LABORATORY AND X-RAY SERVICES.
0245	THESE SERVICES MAY BE BILLED ONLY BY A MEMBER'S HOSPICE PROVIDER.
0246	80022-ROUTINE VENIPUNCTURE SINGLE HOMEBOUND NURSING HOME OR SNF NOT ALLOWED SAME DOS/MEMBER/PROVIDER AS
0247	PHYSICIAN ASSISTANT NUMBER MISSING/INVALID, NOT ELIGIBLE FOR THE DATE OF SERVICE, OR NOT LINKED TO AN INDIVIDUAL
0248	CLAIM DENIED. SURGEON AND ASSISTANT SURGEON BILLING NOT ALLOWED ON SAME FORM.
0249	PAYMENT REDUCED BECAUSE OUR RECORDS SHOW MEMBER WAS NOT I N FACILITY FOR ALL OF THE TOTAL BILLED DAYS.
0250	THIS MEMBER IS NOT ON OUR ELIGIBILITY FILE. PLEASE VERIFY MEMBER MAID NUMBER.
0251	INCORRECT MEMBER IDENTIFICATION NUMBER.
0252	MEMBER NAME ON CLAIM DOES NOT MATCH MEMBER NAME ON THE MEDICAID ELIGIBILITY DATABASE FOR THE MAID NUMBER
0253	OUR RECORDS INDICATE THE MEMBER WAS DECEASED PRIOR TO THE ENDING DATE OF SERVICE.
0254	THE MEMBER IS NOT ELIGIBLE ON THE CLAIM SERVICE DATES.
0255	MEMBER HAS MEDICARE PART B. PLEASE BILL MEDICARE FOR THESE SUPPLIES.
0256	OUR RECORDS INDICATE THAT THIS MEMBER MAY BE ELIGIBLE FOR MEDICARE. PLEASE BILL MEDICARE FIRST. IF MEDICARE DENIES
0257	OUR RECORDS INDICATE THAT THE MEMBER WAS OVER 21 YRS OLD ON THE DATE(S) OF SERVICE. THE MEMBER IS NOT ELIGIBLE FOR
0258	MEDICARE SUSPECT/DENTAL.
	THE MEMBER HAS MEDICARE PART B. PLEASE BILL MEDICARE.
0260	CLAIM DENIED. THE KENTUCKY MEDICAL ASSISTANCE PROGRAM IS ONLY RESPONSIBLE FOR BUY-IN PREMIUMS FOR THIS MEMBER.
0261	OUR RECORDS INDICATE THAT THE MEMBER WAS DECEASED PRIOR T O THE ENDING DATE OF SERVICE.
0262	MEMBER IS NOT ELIGIBLE ON THE DATE OF SERVICE.
0263	CLAIM DENIED. MEMBER NOT ELIGIBLE FOR PORTION OF DATES OF SERVICE.
0264	MEMBER NAME IS MISSING.
0265	INCORRECT MEMBER IDENTIFICATION NUMBER.
-	
0266 0267	MEMBER NOT ELIGIBLE FOR WAIVER SERVICES. WAIVER PAYMENT AMOUNT REDUCED DUE TO MEMBER CONTINUING INCOME
0267	
	MEMBER MAID NUMBER ON CLAIM DOES NOT MATCH THE MEMBER MAID NUMBER ON ATTACHED ELIGIBILITY CARD.
0269	CLAIM DENIED. TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO MEMBERS ENROLLED IN A WAIVER OR HOSPICE
0270	CLAIM DENIED. THIS SERVICE IS NOT PAYABLE FOR A MODEL WAIVER MEMBER.
0271	CLAIM DENIED. MEMBER AVAILABLE INCOME INFORMATION NOT ON FILE FOR THE MONTH OFSERVICE. PLEASE CONTACT DMS AT 1-
0272	CLAIM/DETAIL DENIED. UNIT BILLED AMOUNT CANNOT BE GREATER THAN
0273	CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO CERTAIN TOOTH NUMBERS.
0274	MEMBER TREATMENT AUTHORIZATION INFORMATION NOT FOUND ON INPATIENT HOSPITAL FILE.
0275	INPATIENT HOSPITAL TREATMENT AUTHORIZATION NUMBER MISSING OR INVALID.
0276	DETAIL DENIED. THIS SERVICE NOT PAYABLE FOR EMPOWER NON-EMERGENCY TRANSPORTATION MEMBERS.

EOB Code	Description
0277	THE ATTACHED THIRD PARTY DOCUMENTATION IS NOT SUFFICIENT.CONTACT HPE PROVIDER BILLING INQUIRY FOR ASSISTANCE.
0278	CLAIM DENIED. CLAIM/DOCUMENTATION INDICATES THIRD PARTY PAYMENT WAS RECEIVED BY MEMBER.
0279	CLAIM/DETAIL INDICATES MEMBER HAS OTHER INSURANCE BUT NO INSURANCE AMOUNT ENTERED ON CLAIM.
0280	CLAIM DENIED. YOUR CLAIM INDICATES THIS SERVICE IS DUE TO A WORK-RELATED ACCIDENT/INJURY. PLEASE BILL OTHER
0281	MEMBER HAS OTHER MEDICAL COVERAGE. BILL OTHER INSURANCE FIRST OR ATTACH DOCUMENTATION OF DENIAL FROM THE
0282	THE MEMBER HAS MEDICARE PART A. PLEASE BILL MEDICARE.
0283	OUR RECORDS INDICATE MEMBER HAS MEDICARE PART B, PLEASE BILL MEDICARE.
0284	OUR RECORDS INDICATE THAT THIS MEMBER IS ELIGIBLE FOR HOSPICE COVERAGE BY MEDICARE. PLEASE BILL MEDICARE FIRST.
0285	REGIONAL ANESTHESIA PROCEDURE CODES MAY NOT BE BILLED USING TYPE OF SERVICE 07, MODIFIER AG, OR MORE THAN ONE
0286	THIS PROCEDURE CODE IS LIMITED TO ONE UNIT OF SERVICE PER DATE OF SERVICE.
0287	PROFESSIONAL COMPONENT REVENUE CODE MUST BE BILLED WITH THE CORRESPONDING TECHNICAL COMPONENT REVENUE CODE.
0288	PROFESSIONAL COMPONENT REVENUE CODE MUST BE BILLED WITH CORRESPONDING TECHNICAL REVENUE CODE. CHARGES
0289	CLAIM DENIED. RENDERING PROVIDER NUMBER MISSING OR INVALID.
0290	PENDING CONFIRMATION OF MEMBER ELIGIBILITY.
0291	PENDING POSSIBLE OTHER INSURANCE INVOLVEMENT.
0292	CLAIM SUSPENDED FOR BUY-IN ELIGIBILITY REVIEW.
0293	CLAIM SUSPENDED FOR ELIGIBILITY REVIEW.
0294	KENPAC MEMBER. REFERRING PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PRIMARY PHYSICIAN/CLINIC NUMBER FOR THE
0295	BILLING OR REFERRING KENPAC PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PHYSICIAN/CLINIC FOR DATE(S) BILLED.
0296	CLAIM DENIED. TYPE OF SERVICE DOES NOT MATCH PROCEDURE MODIFIER.
0297	MEMBER IS NOT ELIGIBLE FOR HOSPICE.
0298	MEMBER IS NOT ELIGIBLE FOR HOSPICE FOR BILLED DATES OF SERVICE.
0299	HOSPICE MEMBER. OUR FILES SHOW MEMBER IS COVERED BY ANOTHER HOSPICE PROVIDER FOR BILLED DATE(S) OF SERVICE.
0300	SERVICE PAYS ZERO FOR PRIMARY CARE AND RURAL HEALTH CLAIMS
0301	CLAIM DENIED. RENDERING PROVIDER NOT LISTED AS A MEMBER OF THE BILLING GROUP.
0303	THIS SERVICE MUST BE BILLED FOR A MINIMUM OF 8 UNITS PER DATE OF SERVICE.
0304	OFFICE/EMERGENCY NOT COVERED SAME DATE OF SERVICE AS A NORPLANT/REMOVEL.
0305	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS INVALID FOR THE PROVIDER PROFESSIONAL CODE (1ST DIGIT OF MODIFIER).
0306	A HOSPICE MEMBER - RECYCLE FOR EDIT 298.
0307	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS NOT PAYABLE UNLESS BILLED IN CONJUNCTION WITH OTHER DESIGNATED
0308	DETAIL DENIED. REQUIRED DOCUMENTATION IS MISSING OR DOES NOT VERIFY THAT MEDICAL ASSISTANCE WAS PROVIDED.
0310	CLAIM DENIED. NEW ADMISSION NOT PAYABLE BECAUSE OF NON-COMPLIANCE.
0311	CORRECTED PAYMENT PER ADJUSTMENT REQUEST.
0316	CLAIM/DETAIL PAID. CLAIMS HISTORY REFLECTS THE TOOTH NUMBER PREVIOUSLY EXTRACTED. PLEASE CHECK RECORDS AND VERIFY
0319	INCORRECT PROVIDER NUMBER SUBMITTED - PAYMENT DELAYED.
0320	CLAIM DENIED. EXCEEDS THERAPY LIMITS FOR DRUG CLASS.
0321	EPSDT SCREENING PROCEDURES ARE NOT PAYABLE WITHIN 30 DAYS OF AN EPSDT RELATED PROCEDURES.
0322	EPSDT RELATED PROCEDURES ARE NOT PAYABLE WITHIN 30 DAYS OF AN EPSDT SCREENING PROCEDURES.
0325	CLAIM/DETAIL DENIED. SCREENING PROCEDURE CODE INVALID FOR MEMBER'S AGE.
0326	CLAIM DENIED. BILL/INVOICE MUST ACCOMPANY CLAIM.
0327	PROCEDURE/NDC REQUIRES PRIOR AUTHORIZATION.
0328	PRIMARY SURGICAL PROCEDURE REQUIRES PRIOR AUTHORIZATION.
0329	SECONDARY SURGICAL PROCEDURE REQUIRES PRIOR AUTHORIZATION
0330	DETAIL DENIED. DETAIL UNITS BILLED EXCEED UNITS PRIOR AUTHORIZED.
0331	PAYMENT REDUCED BY AMOUNT PREVIOUSLY PAID. POST OP INCLUDED IN PROCEDURE.
0333	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS REQUIRE PRIOR AUTHORIZATION.
0334	SUPPLY NOT COVERED ON RENTAL ITEM.
0335	LACKS REPORT TO JUSTIFY HIGHER FEE.
0337	CATHETERIZATION PROCEDURES 80021,80023 AND 80024 NOT ALLOWED SAME DOS/MEMBER/PROVIDER.
0340	ONLY THREE FOLLOW UP EXAMS ALLOWED DURING THE SIX MONTH PERIOD FOLLOWING THE FITTING OF A HEARING AID.
0341	AN OFFICE VISIT, ER VISIT OR CONSULTATION ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS A HOSPITAL ADMISSION.
0342	AN OFFICE VISIT AND/OR ER VISIT ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS A CONSULTATION.
0343	CLAIM MASS ADJUSTED DUE TO A RETROACTIVE RATE CHANGE
0344	AN OFFICE VISIT IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS AN EMERGENCY ROOM VISIT.
0345	80020-BLOOD COLLECTION VENIPUNCTURE NOT ALLOWED SAME DOS/ MEMBER/PROVIDER AS 80022-ROUTINE VENIPUNCTURE

FOR Code	Description
0347	DENTURE RELATED EMERGENCY SERVICES AND UPPER OR LOWER DENTURE RELINE NOT PAYABLE ON SAME DATE OF SERVICE.
0348	ROOM CHARGES REDUCED TO SEMI PRIVATE RATE.
0349	EMERGENCY DENTAL PROCEDURES AND EXTRACTION PROCEDURES NOT PAYABLE ON SDOS.
0350	DETAIL DENIED. FILLINGS ARE NOT PAYABLE FOR THE SAME TOOTH AND THE SAME DATE OF SERVICE AS EMERGENCY SERVICES OR
0351	INCORRECT NUMBER OF DAYS COVERED AND NON-COVERED.
0352	CLAIM DENIED. INAPPROPRIATE PROCEDURE CODE USED.
0352	INDIVIDUAL ALLERGY TESTING PROCEDURES ARE NOT PAYABLE WITH W0308-MAXIMUM ALLOWABLE PER ALLERGY TESTING OF
0354	MANUAL PRICE INVALID OR NOT ACCOMPANIED BY A MANUAL PRICE EOB
0355	FEE ADJUSTED TO MAXIMUM ALLOWABLE AMOUNT
0356	CLAIM/DETAIL DENIED AFTER REVIEW BY MEDICAL CONSULTANTS.
0357	CLAIM DENIED. INVOICE MUST HAVE ITEM BILLED NOTED.
0359	REFER TO THE ADJUSTMENT REASON CODE.
0360	FEE ADJUSTED PER CLAIM CREDIT.
0361	GENERAL OPHTHALMOLOGICAL SERVICES NOT PAYABLE ON THE SAME DATE OF SERVICE AS SPECIAL OPHTHALMOLOGICAL SERVICES.
0362	PATIENT LIABILITY APPLIED TO ALLOWED AMOUNT FOR THIS CLAIM.
0363	ROOT REMOVAL NOT PAYABLE ON SAME DATE OF SERVICE AS THE TOOTH EXTRACTION
0364	PAYMENT REDUCED BY OTHER INSURANCE
0365	FEE ADJUSTED TO MAXIMUM ALLOWABLE.
0366	CLAIM DENIED. BILLED AMOUNT MAY NOT EXCEED \$50.00 PER UNIT OF SERVICE.
0367	THIS SERVICE PAID COINSURANCE AND/OR DEDUCTIBLE.
0368	REIMBURSEMENT RATE RECORD NOT FOUND FOR PROVIDER.
0369	ORIGINAL PSYCHIATRIC EVALUATION AND REGULAR HOSPITAL ADMISSION NOT PAYABLE ON SAME DATE OF SERVICE.
0370	PAYMENT MODE NOT FOUND FOR BILLING PROVIDER
0371	REIMBURSEMENT RATE NOT FOUND FOR DATE OF SERVICE
0372	HOSPITAL FOLLOW-UP VISITS AND ORIGINAL PSYCHIATRIC DIAGNOSTIC EVALUATION AND/OR FOLLOW-UP PSYCHIATRIC CARE ARE
0373	UNITS OF SERVICE HAVE BEEN REDUCED TO THE REMAINING PRIOR AUTHORIZED QUANTITY.
0374	REPAYMENT PORTION OF THIS ADJUSTMENT HAS BEEN DENIED. RECOUPMENT IS UNDER FINANCIAL ITEMS.
0375	KYCONV-DESCRIPTION NOT FOUND
0376	CLAIM DENIED. MAC FIELD INVALID.
0377	MEMBER INCOME/PATIENT LIABILITY DEDUCTION NOT APPLICABLE FOR THIS CLAIM.
0378	CLAIM DETAIL DENIED. THIS PROCEDURE CODE IS NOT COVERED.
0379	PAID BY MEDICAID
0380	CO-PAY WAS DEDUCTED FROM REIMBURSEMENT.
0381	CERTAIN SPECIFIED PROCEDURES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE AS EMERGENCY ROOM VISIT
0382	DETAIL DENIED. BILLED AMOUNT FOR IMPLANTABLES MUST BE GREATER THAN \$100.00.
0383	CERTAIN INCIDENTAL SURGERIES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE AS ABDOMINAL SURGERY.
0384	DETAIL DENIED. INVOICE MUST BE ATTACHED WHEN BILLING IMPLANTABLES.
0385	CERTAIN INCIDENTAL PROCEDURES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE AS A D.& C. PROCEDURE.
0386	DETAIL DENIED. INVOICE AMOUNT MUST MATCH BILLED AMOUNT.
0387	CERTAIN INCIDENTAL SURGERIES AND PELVIC SURGERIES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE.
0388	THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE ANCILLARY REVENUE CODE (240). CHARGES MOVED TO
0389	PAID CLAIM BASED UPON MEDICAL REVIEW.
0390	CLAIM DENIED. DUPLICATE SERVICE BILLED.
0391	DETAIL DENIED. PROCEDURE CODES X0091/97535 AND X0103/S5140 NOT PAYABLE ON THE SAME DATE OF SERVICE AS
0392	DETAIL DENIED. PROCEDURE CODES X0061, X0088, AND X0089 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X0091.
0393	CLAIM DENIED. THE PRIMARY DIAGNOSIS CODE IS NOT VALID FOR THIS PROVIDER TYPE.
0394	HOURLY RESPITE SERVICES NOT ALLOWED FOR SAME DATE OF SERVICE AS DAILY RESPITE SERVICES.
0395	THE AMOUNT PAID BY OTHER INSURANCE EQUALS OR EXCEEDS THE AMOUNT OF MEDICAID REIMBURSEMENT FOR THIS SERVICE.
0396	DAILY RESPITE SERVICES NOT ALLOWED FOR SAME DATE OF SERVICE AS HOURLY RESPITE SERVICES.
0397	ACCOMMODATION REVENUE CODES MUST BE BILLED ON AN INPATIENT CLAIM.
0398	CLAIM/DETAIL DENIED. THE PROCEDURE CODE MODIFIER IS MISSING OR INVALID.
0399	CLAIM/DETAIL DENIED. THIS SERVICE NOT COVERED FOR THIS PE MEMBER.
0403	PLEASE GIVE THE DATE(S) OF SURGERY AND RETURN THE INVOICE TO THIS OFFICE.
0404	NURSING FACILITY PRIOR AUTHORIZATION NOT ON FILE - RECYCLE FOR EDIT 332.
0409	INVALID PROVIDER TYPE BILLED ON CLAIM FORM.
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Description	FOB Code	Description
DUE TO THE END OF YOUR RISCAL YEAR, PLEASE REBILL THESE MULTIPLE MONTHS OF SERVICE ON SEPARATE INVOICES - ONE INVOICE 2012 DETAIL DENRIED, CHILD OR DATE OF SERVICE ALLOWED PER DETAIL. 4013 MEMBER NOT RENOULED IN MANAGED CARE DURING DATES OF SERVICE. 4014 MEMBER ROY I ENROLLED IN MANAGED CARE DURING DATES OF SERVICE. 4015 FESCAIM HAS A MANAGED CARE PROVIDER TYPE. 4016 CAPITATION RATE NOT WITHIN DATES OF SERVICE. 4017 CLAIM DEVIDE, INVALID END MISSING CAPITATION INDICATOR. 4018 CLAIM DEVIDE, INVALID END MISSING CAPITATION INDICATOR. 4019 CLAIM DEVIDE, INVALID END RESERVED TARE. 4020 CLAIM DEVIDE, INVALID END RESERVED TARE. 4021 CLAIM DEVIDE, INVALID END RESERVED TARE. 4022 CLAIM DEVIDE, INVALID END RESERVED TARE. 4023 CLAIM DEVIDE, INVALID END RATES OF SERVICE. 4024 CLAIM DEVIDE, INVALID END RATES OF SERVICE. 4025 CLAIM DEVIDE, INVALID END RATES OF SERVICE. 4026 CLAIM DEVIDE, INVALID END RATES OF SERVICE. 4026 CLAIM DEVIDE, INVALID END RATES OF SERVICE. 4027 CLAIM DEVIDE, INVALID END RATES OF SERVICE. 4028 CLAIM DEVIDE, INVALID END RATES OF SERVICE. 4029 DETAIL DEVIDE, INVALID END RATES OF SERVICE. 4029 DETAIL DEVIDE, INVALID MEMBER NOT ELIG FOR REHAVIORAL. 4020 CLAIM DEVIDE, INVALID MEMBER NOT ELIG FOR REHAVIORAL. 4021 CLAIM DEVIDE, INVALID MEMBER NOT ELIG FOR REHAVIORAL. 4022 CLAIM DEVIDE, INVALID MEMBER NOT ELIG FOR BEHAVIORAL. 4023 CLAIM DEVIDE, INVALID MEMBER SERVICE HAS BEEN EXCEEDED. THE 4024 CLAIM DEVIDE, DEVIDENCE CODE NOT A COVERED SERVICE. 4025 CLAIM DEVIDE, DEVIDENCE CODE NOT A COVERED SERVICE. 4026 CLAIM DEVIDE, DEVIDENCE CODE NOT A COVERED SERVICE. 4027 CLAIM DEVIDE, DEVIDENCE CODE NOT AND RELATED BAD CLAIM WITH JUSTIFICATION FOR DUPLICATED SERVICE. 4028 CLAIM DEVIDE, DEVIDENCE PROVIDERS OF BEHAVIORAL HEALTH MANAGED CARE. 4029 CLAIM DEVIDE, DEVIDENCE PROVIDERS OF BEHAVIORAL HEALTH MANAGED CARE. 4031 CLAIM DEVIDE, DEVIDENCE PROVIDERS OF BEHAVIORAL HEALTH MANAGED CARE. 4032 CLAIM DEVIDE, DEVIDENCE PROVIDERS OF BEHAVIORAL HEALTH MANAGED CARE. 4033 CLAIM DEVIDE, DEVIDENC		
DETAIL DENIED, ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL. 1313 MEMBER ENT DENIED, LID IN MANAGED CARE DURING DATES OF SERVICE. 1414 MEMBER ENTOLED IN MANAGED CARE DURING DATES OF SERVICE. 1415 FES CLAIM HAS A MANAGED CARE POWINGER TYPE. 1416 CAPITATION RATE NOT WITHIN DATES OF SERVICE. 1417 CLAIM DENIED, INVALID OR MISSING CAPITATION INDICATOR. 1417 CLAIM DENIED, INVALID DENIED SECONDER TYPE. 1419 CLAIM DENIED, INVALID DEN COUNTER TYPE. 1419 CLAIM DENIED, INVALID DEN CREATER TYPE. 1419 CLAIM DENIED, INVALID ENC PRAYMENT AMOUNT. 1421 CLAIM DENIED, INVALID ENC PAYMENT AMOUNT. 1421 CLAIM DENIED, INVALID ENC PAYMENT TON. 1422 CLAIM DENIED, INVALID ENC PAYMENT TON. 1422 CLAIM DENIED, INVALID ENC PAYMENT TON. 1423 CLAIM DENIED, INVALID MEMBER NOT ELIG FOR PHYSICAL. 1424 CLAIM DENIED, INVALID MEMBER NOT ELIG FOR PHYSICAL. 1424 CLAIM DENIED, INVALID MEMBER NOT ELIG FOR PHYSICAL. 1425 CLAIM DENIED, INVALID MEMBER NOT ELIG FOR DENIS PROVINCE. 1426 CLAIM DENIED, INVALID MEMBER NOT ELIG FOR DENIS PROVINCE. 1426 CLAIM DENIED, INVALID MEMBER NOT ELIG FOR DENIS PROVINCE. 1427 CLAIM DENIED, INVALID MEMBER NOT ELIG FOR BENEVICE. 1428 CLAIM DENIED, INVALID MEMBER NOT ELIG FOR BENEVICE. 1429 CLAIM DENIED, INVALID MEMBER NOT ELIG FOR BENEVICE. 1429 CLAIM DENIED, INVALID MEMBER NOT ELIG FOR BENEVICE. 1420 CLAIM DENIED, PROCEDURE CODE NOT A COVERED SERVICE. 1421 CLAIM DENIED, PROVINCE PRO		
MEMBER NOT ENROLLED IN MANAGED CARE DURING DATES OF SERVICE. 1114 112 113 114 115 115 115 115 115 115		
MEMBER ENROLLED IN MANAGED CARE DURING DATES OF SERVICE. 1515 152 153 154 155 155 154 154 155 155		
0415 CAPTATION RATE NOT WITHIN DATES OF SERVICE. 0417 CLAIM DENIED. INVALID OR MISSING CAPITATION INDICATOR. 0418 CAPTATION RATE NOT WITHIN DATES OF SERVICE. 0419 CLAIM DENIED. INVALID ENCOUNTER TYPE. 0420 CLAIM DENIED. INVALID ENCOUNTER TYPE. 0421 CLAIM DENIED. INVALID ENCOUNTER TYPE. 0422 CLAIM DENIED. INVALID ENCOUNTER TYPE. 0422 CLAIM DENIED. INVALID ENC PARMINITY AMOUNT. 0423 CLAIM DENIED. INVALID ENC PARMINITY AMOUNT. 0423 CLAIM DENIED. INVALID ENC PARMINITY AMOUNT. 0424 CLAIM DENIED. INVALID ENC PARMINITY AMOUNT. 0425 CLAIM DENIED. INVALID ENC PARMINITY AMOUNT. 0426 CLAIM DENIED. INVALID MEMBER NOT ELIG FOR PHYSICAL. 0427 CLAIM DENIED. INVALID MEMBER NOT ELIG FOR PHYSICAL. 0428 CLAIM DENIED. INVALID MEMBER NOT ELIG FOR BEHAVIORAL. 0429 DETAIL DENIED. PROCEDURE CODE NOT A COVERED SERVICE. 0426 THE 36 MONTH MAXIMUM FOR THIS SERVICE HAS BEEN EXCEDED. THE 0427 CLAIM DENIED. RIVED DENIED CONTROL TO A COVERED SERVICE. 0428 FS NOT ALLOWED, MEMBER ELIGIBLE FOR BEHAVIORAL HEALTH MANAGED CARE. 0429 CLAIM DENIED. PARTINESSHIP NUM MISMATCH 0430 CLAIM DENIED. RIVED WITH AN ADMINISTRY ON RELATED PAD CLAIM WITH JUSTIFICATION FOR DUPLICATED SERVICE. 0429 CLAIM DENIED. SECONITYER, INV. TON TO CREDIT 0431 RESERVED FOR MANAGED CARE. 0430 CLAIM DENIED. SECONITYER, INV. TON TO CREDIT 0431 RESERVED FOR MANAGED CARE. 0432 CLAIM DENIED. SECONITYER, INV. TON TO CREDIT 0432 CLAIM DENIED. SECONITYER, INV. TON TO CREDIT 0433 CLAIM DENIED. SECONITYER, INV. TON TO CREDIT 0434 RESERVED FOR MANAGED CARE. 0435 CLAIM/DETAIL DENIED. SECONITY RIVER SERVICES ARE ONLY PAYABLE TO THE PRIMARY SEL PROVIDER FOR THIS MEMBER. 0436 CLAIM/DETAIL DENIED. SEL WAVER SERVICES ARE ONLY PAYABLE TO THE PRIMARY SEL PROVIDER FOR THIS MEMBER. 0437 CLAIM/DETAIL DENIED. SEL WAVER SERVICES ARE ONLY PAYABLE ON THE SEMBLE PER PROVIDER. 0438 CLAIM/DETAIL DENIED. PROCEDURE CODE SEL LIMITED TO LINITS PER CALENDAR WEEK, PER MEMBER, PER PROVIDER. 0440 CLAIM/DETAIL DENIED. PROCEDURE CODE SEL LIMITED TO LINITS PER DAY, PER MEMBER, PER PROVIDER. 0441 CLAIM/DETAIL DENIED.		
CAPITATION RATE NOT WITHIN DATES OF SERVICE.		
CLAIM DENIED, INVALID OR MISSING CAPITATION INDICATOR.		
CLAIM DENIED, INVALID ENCOUNTER TYPE 10420 CLAIM DENIED, INVALID ENC PAYMENT DATE. 10421 CLAIM DENIED, INVALID ENC PAYMENT DATE. 10422 CLAIM DENIED, INVALID ENC PAYMENT DATE. 10422 CLAIM DENIED, INVALID ENC PAYMENT DATE. 10423 CLAIM DENIED, INVALID ENC PAYMENT DATE. 10424 CLAIM DENIED, INVALID ENC PAYMENT DATE. 10424 CLAIM DENIED, INVALID ENC PAYMENT TON. 10424 CLAIM DENIED, INVALID MEMBER NOT ELIG FOR PHYSICAL. 10425 CLAIM DENIED, INVALID MEMBER NOT ELIG FOR PHYSICAL. 10426 CLAIM DENIED, INVALID MEMBER NOT ELIG FOR BEHAVIORAL. 10426 CLAIM DENIED, PROCEDURE CODE NOT A COVERED SERVICE. 10427 CLAIM DENIED, PROCEDURE CODE NOT A COVERED SERVICE. 10427 CLAIM DENIED, PROCEDURE CODE NOT A COVERED SERVICE. 10428 FFS NOT ALLOWED, MEMBER ELIGIBLE FOR BEHAVIORAL HEALTH MANAGED CARE. 10429 CLAIM DENIED, RESUBBINT AN ADJUSTMENT ON BELATED PAID CLAIM WITH JUSTIFICATION FOR DUPLICATED SERVICE. 10429 CLAIM DENIED, DRATTINERSHIP PAUM MISMATCH 10430 CLAIM DENIED, DRATTINERSHIP PAUM MISMATCH 10431 RESERVED FOR MANAGED CARE. 10431 CLAIM DENIED, SEQRI MISMATCH ACROSS CLAIM. 10431 CLAIM DENIED, SEQRI MISMATCH ACROSS CLAIM. 10431 CLAIM DENIED, SEQRI MISMATCH ACROSS CLAIM. 10432 CLAIM DENIED, SEQRI MISMATCH ACROSS CLAIM. 10433 CLAIM DENIED, DRATTINERSHIP SUBLIVIAL FOR TOR XVPER. 10435 CLAIM DENIED, SEQRI MISMATCH ACROSS CLAIM. 10434 CLAIM DENIED, SEQRI MISMATCH ACROSS CLAIM. 10435 CLAIM DENIED, SEQRI MISMATCH ACROSS CLAIM. 10440 CLAIM/DETAIL DENIED, SCL WARVES SERVICES ARE ONLY PAYABLE TO THE PRIMARY SCL PROVIDER FOR THIS MEMBER. 10451 CLAIM DENIED, SCL WARVES SERVICES ARE ONLY PAYABLE TO THE PRIMARY SCL PROVIDER FOR THIS MEMBER. 10452 CLAIM DETAIL DENIED, SCL WARVES SERVICES ARE ONLY PAYABLE TO THE PRIMARY SCL PROVIDER TON AN INPATIENT HOSPITAL. 10453 CLAIM/DETAIL DENIED, SCL WARVES SERVICES ARE ONLY PAYABLE TO THE PRIMARY SCL PROVIDER TON AN INPATIENT HOSPITAL. 10464 CLAIM/DETAIL DENIED, PROCEDURE CODE 93933 IS LIMITED TO 1 UNIT PER MEMBER, PER PROVIDER. 10475 CLAIM/DETAIL DENIED, PROCEDURE CODE 9334 AND 10451 CLAIM SERVICE YOUR SE		
CLAIM DENIED, INVALID ENC RECEIPT DATE CLAIM DENIED, INVALID ENC PAYMENT AMOUNT. CLAIM DENIED, INVALID ENC PAYMENT CANCE. CLAIM DENIED, INVALID ENCE DUISTMENT TON. CLAIM DENIED, INVALID ENCE DUISTMENT TON. CLAIM DENIED, INVALID MEMBER NOT ELIG FOR PHYSICAL. CLAIM DENIED, INVALID MEMBER NOT ELIG FOR PHYSICAL. CLAIM DENIED, INVALID MEMBER NOT ELIG FOR PHYSICAL. CLAIM DENIED, INVALID MEMBER NOT ELIG FOR BEHAVIORAL. CLAIM DENIED, INVALID MEMBER NOT ACOVERED SERVICE. DA25 CLAIM DENIED, RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM WITH JUSTIFICATION FOR DUPLICATED SERVICE. CLAIM DENIED, PARTNERSHIP NUM MISMATCH CLAIM DENIED, PARTNERSHIP NUM MISMATCH CLAIM DENIED, PROTUNTER, INV. TOT TO KEDIT CLAIM DENIED, PROTUNTER, INV. TOT TO KEDIT CLAIM DENIED, PROTUNTER, INV. TOT TO KEDIT CLAIM DENIED, SED MISMATCH ACROSS CLAIM. CLAIM DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO 1 UNIT PER MEMBER, PER PIVE YEARS. CLAIM DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO 1 UNIT PER MEMBER, PER PROVIDER FOR THIS MEMBER. CLAIM DETAIL DENIED. PROCEDURE CODE IS SIMITED TO 1 UNIT PER MEMBER, PER PROVIDER. CLAIM/DETAIL DENIED. PROCEDURE CODE SOBS IS LIMITED TO 1 UNIT PER MEMBER, PER PROVIDER. CLAIM/DETAIL DENIED. PROCEDURE CODE SOBS IS LIMITED TO 1 UNIT PER MEMBER, PER PROVIDER. CLAIM/DETAIL DENIED. PROCEDURE CODE SOBS IS LIMITED TO 1 UNIT PER MEMBER, PER PROVIDER. CLAIM/DETAIL DENIED. PROCEDURE CODE SOBS IS LIMITED TO 1 UNIT PER MEMBER, PER PROVIDER. CLAIM/DETAIL DENIED. PROCEDURE CODE SOBS IS LIMITED TO 1 UNIT PER MEMBER, PER PROVIDER. CLAIM/DETAIL DEN	-	
0421 CLAIM DENIED. INVALID ENC PAYMENT AND UNIT. 0421 CLAIM DENIED. INVALID ENC PAYMENT DATE. 0422 CLAIM DENIED. INVALID ENC PAYMENT DATE. 0423 CLAIM DENIED. INVALID ENC ADJUSTMENT TON. 0424 CLAIM DENIED. INVALID MEMBER NOT ELIG FOR PHYSICAL. 0424 CLAIM DENIED. INVALID MEMBER NOT ELIG FOR PHYSICAL. 0425 DETAIL DENIED. PROCEDURE CODE NOT A COVERED SERVICE. 0426 THE 36 MONTH MANUMUM FOR THIS SERVICE HAS BEEN EXCESEDD. THE 0427 CLAIM DENIED. RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM WITH JUSTIFICATION FOR DUPLICATED SERVICE. 0428 FES NOT ALLOWED, MEMBER ELIGIBLE FOR BEHAVIORAL HEALTH MANAGED CARE. 0429 CLAIM DENIED. RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM WITH JUSTIFICATION FOR DUPLICATED SERVICE. 0429 CLAIM DENIED. BROQUNTER, INV. TON TO CREDIT 0431 RESERVED FOR MANAGED CARE. 0431 RESERVED FOR MANAGED CARE. 0432 CLAIM DENIED. SEQUE MISMATCH ACROSS CLAIM. 0433 CLAIM DENIED. SEQUE MISMATCH ACROSS CLAIM. 0433 CLAIM DENIED. SEQUE MISMATCH ACROSS CLAIM. 0434 RESERVED FOR MANAGED CARE. 0435 CLAIM DENIED. SEQUE MISMATCH ACROSS CLAIM. 0436 CLAIM DENIED. SEQUE MISMATCH ACROSS CLAIM. 0437 CLAIM DENIED. SEQUE MISMATCH ACROSS CLAIM. 0438 CLAIM DENIED. SEQUE MISMATCH ACROSS CLAIM. 0438 CLAIM DENIED. SEQUE MISMATCH ACROSS CLAIM. 0439 CLAIM DENIED. SEQUE MISMATCH ACROSS CLAIM. 0430 CLAIM DENIED. SEQUE MISMATCH ACROSS CLAIM. 0431 RESERVED FOR MANAGED CARE. 0432 CLAIM DENIED. SEQUE MISMATCH ACROSS CLAIM. 0433 CLAIM DENIED. SEQUE MISMATCH ACROSS CLAIM. 0434 RESERVED FOR MANAGED CARE. 0435 CLAIM DENIED. SEQUE MISMATCH ACROSS CLAIM. 0436 CLAIM DENIED. SEQUE MISMATCH ACROSS CLAIM. 0437 CLAIM DENIED. SEQUE MISMATCH ACROSS CLAIM. 0438 CLAIM DENIED. SEQUE MISMATCH ACROSS CLAIM. 0439 CLAIM DENIED. SEQUE MISMATCH ACROSS CLAIM. 0439 CLAIM DENIED. CERTAIN OUTPATIENT HOSPITAL CHARGES ARE NOT PAYABLE TO THE PRIMARY SCL PROVIDER FOR THIS MEMBER. 0439 CLAIM DETAIL DENIED. PROCEDURE CODE 90853 IS LIMITED TO 1 UNITY PER CALENDAR WEEK, PER MEMBER, PER PROVIDER. 0440 CLAIM DETAIL DENIED. REPOCEDURE CODE 90853 IS LIMITED TO 1 UNITY PER CALEN	-	
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CLAIM/DETAIL DENIED. X0079 LIMITED TO 8 UNITS PER DAY. 0448 MEMBER NOT ON ELIGIBILITY FILE - SUSPEND FOR EDIT 250. 0449 THE MEMBER ELIGIBILITY MAID NUMBER ON THE MEDICAID CARD ATTACHED WITH YOUR CLAIM IS INCORRECT. 0450 CLAIM DETAIL DENIED. ASSESSMENT PROCEDURES ARE LIMITED TO ONE (1) PER MEMBER, PER PROVIDER DURING THE MEMBER'S 0451 CLAIM DETAIL DENIED. UNABLE TO APPLY ASSESSMENT PROCEDURE LIMITATION DUE TO NO CASE MANAGEMENT ON PRIOR 0452 CLAIM/DETAIL DENIED. X0080/H0004 LIMITED TO 12 UNITS PER WEEK. 0453 CLAIM/DETAIL DENIED. X0061/T2016, X0088/S5126, X0089/H0043, AND X0103/S5140 LIMITED TO 1 UNIT, CUMULATIVELY, PER DAY. 0454 CLAIM/DETAIL DENIED. X0079/H0039 LIMITED TO 32 UNITS PER DAY. 0455 CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY. 0456 CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. 0457 CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATIVELY, PER DAY. 0458 CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO 5150.00 PER DAY. 0459 CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO 5150.00 PER DAY. 0450 CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO 5150.00 PER DAY. 0461 CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. 0462 PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX. 0463 PAY TPL CLAIM.	0445	CLAIM/DETAIL DENIED. PROCEDURE CODE 99244 IS LIMITED TO ONE PER FIVE YEARS, PER MEMBER, PER PROVIDER.
MEMBER NOT ON ELIGIBILITY FILE - SUSPEND FOR EDIT 250. 1 THE MEMBER ELIGIBILITY MAID NUMBER ON THE MEDICAID CARD ATTACHED WITH YOUR CLAIM IS INCORRECT. 1 CLAIM DETAIL DENIED. ASSESSMENT PROCEDURES ARE LIMITED TO ONE (1) PER MEMBER, PER PROVIDER DURING THE MEMBER'S 2 CLAIM DETAIL DENIED. UNABLE TO APPLY ASSESSMENT PROCEDURE LIMITATION DUE TO NO CASE MANAGEMENT ON PRIOR 3 CLAIM/DETAIL DENIED. X0080/H0004 LIMITED TO 12 UNITS PER WEEK. 4 CLAIM/DETAIL DENIED. X0061/T2016, X0088/S5126, X0089/H0043, AND X0103/S5140 LIMITED TO 1 UNIT, CUMULATIVELY, PER DAY. 5 CLAIM/DETAIL DENIED. X0079/H0039 LIMITED TO 32 UNITS PER DAY. 6 CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY. 6 CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. 6 CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATIVELY, PER DAY. 6 CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO \$150.00 PER DAY. 6 CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO \$150.00 PER DAY. 6 CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CALENDAR YEAR. 6 CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. 6 CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. 6 CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. 6 CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. 6 CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. 6 CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. 6 CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. 6 CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. 6 CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY.	0446	CLAIM/DETAIL DENIED. PROCEDURE CODE 99245 IS LIMITED TO ONE PER FIVE YEARS, PER MEMBER, PER PROVIDER.
THE MEMBER ELIGIBILITY MAID NUMBER ON THE MEDICAID CARD ATTACHED WITH YOUR CLAIM IS INCORRECT. OLAIM DETAIL DENIED. ASSESSMENT PROCEDURES ARE LIMITED TO ONE (1) PER MEMBER, PER PROVIDER DURING THE MEMBER'S CLAIM DETAIL DENIED. UNABLE TO APPLY ASSESSMENT PROCEDURE LIMITATION DUE TO NO CASE MANAGEMENT ON PRIOR CLAIM/DETAIL DENIED. X0080/H0004 LIMITED TO 12 UNITS PER WEEK. CLAIM/DETAIL DENIED. X0061/T2016, X0088/S5126, X0089/H0043, AND X0103/S5140 LIMITED TO 1 UNIT, CUMULATIVELY, PER DAY. CLAIM/DETAIL DENIED. X0079/H0039 LIMITED TO 32 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATIVELY, PER DAY. CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO \$150.00 PER DAY. CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CALENDAR YEAR. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY.	0447	CLAIM/DETAIL DENIED. X0079 LIMITED TO 8 UNITS PER DAY.
CLAIM DETAIL DENIED. ASSESSMENT PROCEDURES ARE LIMITED TO ONE (1) PER MEMBER, PER PROVIDER DURING THE MEMBER'S CLAIM DETAIL DENIED. UNABLE TO APPLY ASSESSMENT PROCEDURE LIMITATION DUE TO NO CASE MANAGEMENT ON PRIOR CLAIM/DETAIL DENIED. X0080/H0004 LIMITED TO 12 UNITS PER WEEK. CLAIM/DETAIL DENIED. X0061/T2016, X0088/S5126, X0089/H0043, AND X0103/S5140 LIMITED TO 1 UNIT, CUMULATIVELY, PER DAY. CLAIM/DETAIL DENIED. X0079/H0039 LIMITED TO 32 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATIVELY, PER DAY. CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO \$150.00 PER DAY. CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CALENDAR YEAR. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK. CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK. CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK. CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK.	0448	MEMBER NOT ON ELIGIBILITY FILE - SUSPEND FOR EDIT 250.
CLAIM/DETAIL DENIED. UNABLE TO APPLY ASSESSMENT PROCEDURE LIMITATION DUE TO NO CASE MANAGEMENT ON PRIOR CLAIM/DETAIL DENIED. X0080/H0004 LIMITED TO 12 UNITS PER WEEK. CLAIM/DETAIL DENIED. X0061/T2016, X0088/S5126, X0089/H0043, AND X0103/S5140 LIMITED TO 1 UNIT, CUMULATIVELY, PER DAY. CLAIM/DETAIL DENIED. X0079/H0039 LIMITED TO 32 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATIVELY, PER DAY. CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO \$150.00 PER DAY. CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CALENDAR YEAR. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK. PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX. PAY TPL CLAIM.	0449	THE MEMBER ELIGIBILITY MAID NUMBER ON THE MEDICAID CARD ATTACHED WITH YOUR CLAIM IS INCORRECT.
CLAIM/DETAIL DENIED. X0080/H0004 LIMITED TO 12 UNITS PER WEEK. CLAIM/DETAIL DENIED. X0061/T2016, X0088/S5126, X0089/H0043, AND X0103/S5140 LIMITED TO 1 UNIT, CUMULATIVELY, PER DAY. CLAIM/DETAIL DENIED. X0079/H0039 LIMITED TO 32 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATIVELY, PER DAY. CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO \$150.00 PER DAY. CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CALENDAR YEAR. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK. PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX.	0450	CLAIM DETAIL DENIED. ASSESSMENT PROCEDURES ARE LIMITED TO ONE (1) PER MEMBER, PER PROVIDER DURING THE MEMBER'S
CLAIM/DETAIL DENIED. X0061/T2016, X0088/S5126, X0089/H0043, AND X0103/S5140 LIMITED TO 1 UNIT, CUMULATIVELY, PER DAY. CLAIM/DETAIL DENIED. X0079/H0039 LIMITED TO 32 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATIVELY, PER DAY. CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO \$150.00 PER DAY. CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CALENDAR YEAR. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK. PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX.	0451	CLAIM DETAIL DENIED. UNABLE TO APPLY ASSESSMENT PROCEDURE LIMITATION DUE TO NO CASE MANAGEMENT ON PRIOR
CLAIM/DETAIL DENIED. X0079/H0039 LIMITED TO 32 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATIVELY, PER DAY. CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO \$150.00 PER DAY. CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CALENDAR YEAR. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK. CHAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK. PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX. PAY TPL CLAIM.	0452	CLAIM/DETAIL DENIED. X0080/H0004 LIMITED TO 12 UNITS PER WEEK.
CLAIM/DETAIL DENIED. X0079/H0039 LIMITED TO 32 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATIVELY, PER DAY. CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO \$150.00 PER DAY. CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CALENDAR YEAR. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK. CHAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK. PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX. PAY TPL CLAIM.	0453	CLAIM/DETAIL DENIED. X0061/T2016, X0088/S5126, X0089/H0043, AND X0103/S5140 LIMITED TO 1 UNIT, CUMULATIVELY, PER DAY.
CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATIVELY, PER DAY. CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO \$150.00 PER DAY. CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CALENDAR YEAR. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK. PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX. O463 PAY TPL CLAIM.	0454	CLAIM/DETAIL DENIED. X0079/H0039 LIMITED TO 32 UNITS PER DAY.
CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATIVELY, PER DAY. CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO \$150.00 PER DAY. CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CALENDAR YEAR. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK. PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX. PAY TPL CLAIM.	0455	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY.
CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO \$150.00 PER DAY. CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CALENDAR YEAR. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK. PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX. PAY TPL CLAIM.	0456	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY.
CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO \$150.00 PER DAY. CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CALENDAR YEAR. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK. PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX. PAY TPL CLAIM.	0457	CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATIVELY, PER DAY.
CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CALENDAR YEAR. CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK. PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX. PAY TPL CLAIM.	0458	
0461 CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK. 0462 PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX. 0463 PAY TPL CLAIM.	0459	
0462 PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX. 0463 PAY TPL CLAIM.	0460	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY.
0463 PAY TPL CLAIM.	0461	CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK.
	0462	PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX.
0464 PAY AND BILL TPL CLAIM.	0463	PAY TPL CLAIM.
	0464	PAY AND BILL TPL CLAIM.

EOB Code	Description
	MEMBER COVERED BY PRIVATE INSURANCE (NO ATTACHMENT).
0466	DETAIL DENIED. EARLY INTERVENTION AND CERTAIN EPSDT-SPECIAL SERVICES PROCEDURES ARE NOT PAYABLE ON THE SAME DATE
0467	MEMBER HAS OTHER MEDICAL COVERAGE. BILL OTHER INSURANCE FIRST OR ATTACH DOCUMENTATION OF DENIAL FROM THE
0469	CLAIM/DETAIL DENIED. COMPANION CARE UNITS ARE LIMITED TO 200 PER WEEK.
0472	MEMBERS LIMITED TO ONE DRUG CLASS(GPPC) 681200 PRISCRIPTION/REFILL PER DATE OF SERVICE.
0473	MEDICAID REIMBURSEMENT FOR THIS DATE OF SERVICE HAS ALREADY BEEN MADE. CLAIM PAYMENT SET TO ZERO.
0476	MEMBER IN AN INSTITUTIONAL SETTING DURING THE SAME DATE OF SERVICE.
0477	MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATES OF SERVICE.
0478	YOUR FACILITY HAS PREVIOUSLY BILLED AND RECEIVED PAYMENT FOR ALL OR A PORTION OF THESE DATES OF SERVICE.
0479	CLAIM DENIED. SERVICES FOR THESE DATES OF SERVICE HAVE BEEN PAID TO A NON-HOSPICE PROVIDER.
0481	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.
0482	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.
0483	DUPLICATE ANESTHESIA SERVICE BILLED BY PHYSICIAN AND NURSE ANESTHETIST.
0484	ONLY ONE ANESTHESIA ALLOWED PER DOS PER MEMBER.
0486	DETAIL PLACE OF SERVICE NOT COVERED THROUGH THE PODIATRY PROGRAM.
0487	ROUTINE FOOT CARE IS NOT PAYABLE FOR THIS DIAGNOSIS.
0489	CLAIM DENIED. THIS SERVICE WAS PREVIOUSLY PAID TO ANOTHER PROVIDER.
0490	CONSECUTIVE OUTPATIENT SERVICES ARE NON-PAYABLE DURING A HOSPITAL INPATIENT STAY.
0491	CLAIM DENIED. MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATES OF SERVICE.
0492	CLAIM/DETAIL DENIED. DCBS MEMBERS MAY NOT RECEIVE TITLE V SERVICES AND IMPACT PLUS/CHMC SERVICES ON THE SAME DATE
0493	CLAIM/DETAIL DENIED. DCBS MEMBERS MAY NOT RECEIVE THE SAME DCBS MENTAL HEALTH SERVICES FROM TWO DIFFERENT SUB-
0494	DETAIL DENIED. THIS SERVICE IS NOT PAYABLE BEYOND THE BIRTH MONTH OF THE MEMBER'S 18TH BIRTHDAY.
0496	ONLY ONE (1) ANESTHESIA\IV SEDATION ALLOWED PER DATE OF SERVICE PER MEMBER.
0497	CLAIM/DENIED. RESUBMIT AN ADJUSTMENT ON HPE ADJUSTMENT REQUEST FORM.
0498	CLAIM DENIED. ONLY ONE PAYMENT ALLOWED PER MEMBER, PER DATE OF SERVICE.
0499	CLAIM PENDING REVIEW OF HISTORY.
0500	CLAIM DENIED. BIFOCAL OR SINGLE VISION LENSES LIMITED TO TWO SETS PER 12 MONTHS.
0501	PROFESSIONAL FEE-DISPENSING SERVICE ALLOWED ONE PER 12 MONTHS PER MEMBER.
0502	ONE FAMILY PLANNING SERVICE PER DOS.
0503	ANNUAL FAMILY PLANNING VISITS LIMITED TO 1 PER MEMBER PER NINE MONTHS PER CLINIC.
0504	FAMILY PLANNING MEMBERS LIMITED TO ONE INITIAL VISIT PER PROVIDER PER THREE YEAR PERIOD.
0505	MEMBER IN INSTITUTIONAL SETTING DURING SAME DATE OF SERVICE.
0506	CBC AND COMPONENTS NOT ALLOWED SAME DOS.
0507	PACKAGE OF 12 TESTS AND COMPONENTS NOT ALLOWED SAME DOS.
0508	COMPLETE BLOOD COUNT AND COMPONENTS NOT ALLOWED SAME DOS.
0509	MEMBERS ARE LIMITED ON INITIAL AND FOLLOW UP VISITS TO ONE PER YEAR PER PROVIDER FOR DOS PRIOR TO SEPT. 1, 1985.
0510	MEMBERS LIMITED ON SELECTED INITIAL AND FOLLOW UP VISITS TO 1 PER DATE OF SERVICE.
0511	PAYMENT FOR REVISION OF ARTERIOVENOUS SHUNT IS INCLUDED IN FEE FOR INITIAL INSERTION WHEN REVISION IS PERFORMED
0512	CLAIM DENIED. FOLLOW UP VISIT INCLUDED IN REIMBURSEMENT FOR DELIVERY.
0513	CLAIM DENIED. FOLLOW-UP HOSPITAL VISITS INCLUDED IN REIMBURSEMENT FOR C-SECTION.
0514	CAST APPLICATION/REMOVAL INCLUDED IN REIMBURSEMENT FOR SURGERY.
0515	CLAIM DENIED CULTURES/SMEARS NOT ALLOWED SAME DOS FOR SAME CONDITION.
0516	EXTRACTION OR EXPOSURE OF TOOTH DISALLOWED IF PREVIOUSLY EXTRACTED OR EXPOSED.
0517	CLAIM DENIED. EMERGENCY SERVICES LIMITED TO ONE PER DOS PER MEMBER PER PROVIDER.
0518	CLAIM/DETAIL DENIED. INITIAL TOOTH EXTRACTION LIMITED TO ONE PER DOS/MEMBER/PROVIDER. USE PROCEDURE 07120 FOR
0519	CLAIM DENIED. REIMBURSEMENT FOR CIRCUMCISION WITHIN TEN DAYS OF DELIVERY IS INCLUDED IN DELIVERY FEE.
0520	MAINTENANCE DRUG DAYS SUPPLY LESS THAN 30 DAYS.
0521	COMPREHENSIVE CLIENT RE-EVALUATION NOT ALLOWED WITHIN 12 MONTHS OF COMPREHENSIVE CLIENT EVALUATION.
0522	COMPREHENSIVE CLIENT RE-EVALUATION LIMITED TO ONCE PER LIFE TIME.
0523	RESIDENTIAL COMPONENT SERVICE NOT ALLOWED WITH IN-HOME SCL SERVICES ON THE SAME DOS.
0524	IN-HOME SCL SERVICES NOT ALLOWED WITH RESIDENTIAL COMPONENT SERVICES ON THE SAME DOS.
0525	IN-PATIENT MEMBERS ARE LIMITED TO ONE ATTENDANCE AND ONE CONSULTATION PER ADMISSION.
0526	IN-PATIENT MEMBERS WHO HAVE HAD ORAL SURGERY ARE LIMITED TO 1 ATTENDANCE AND/OR 1 CONSULTATION PER DATE OF
0527	ADDITIONAL SERVICES TO THE SAME TOOTH ARE DISALLOWED IF THE TOOTH HAS BEEN PREVIOUSLY EXTRACTED.
0528	ADDITIONAL SERVICES TO THE SAME TOOTH ARE DISALLOWED ON THE SAME DOS AS A CROWN PROCEDURE OR A FRACTURED

FOR Code	Description
0529	CROWN AND BUILD UP PROCEDURES ARE DISALLOWED IF ADDITIONAL DENTAL SERVICES HAVE BEEN PAID FOR THE SAME TOOTH
0530	CLAIM PAID. CLAIM HAS BEEN REDUCED BY THE AMOUNT OF THE DISPENSING FEE.
0531	PURCHASE UNITS BILLED EXCEEDS MAXIMUM ALLOWED FOR THIS PRIOR AUTHORIZATION CHECK YOUR MAP-9 FORM.
0532	RENTAL UNITS/CHARGES BILLED EXCEEDS MAXIMUM ALLOWED FOR THIS PRIOR AUTHORIZATION CHECK YOUR MAP-9 FORM.
0533	CLAIM DENIED. PRIOR AUTHORIZATION NOT ON FILE OR DOES NOT MATCH CLAIM INFORMATION.
0534	CLAIM DENIED. PROCEDURE CODE X0064 CANNOT BE BILLED IN CONJUNCTION WITH OTHER PROCEDURE CODES.
0535	PLEASE BILL BABY'S HOSPITAL STAY AFTER MOTHER'S DISCHARGE ON SEPARATE CLAIM FORM, USING BABY'S OWN NAME AND
0536	THE MEDICARE EOMB INDICATES THIS IS A DUPLICATE BILLING. PLEASE SUBMIT THE ORIGINAL EOMB INDICATING THE DEDUCTIBLE
0537	CLAIM/DETAIL DENIED. THIS PROCEDURE SHALL NOT BE PAID SEPARATELY WHEN THE GLOBAL SERVICE HAS BEEN REPORTED.
0538	CLAIM/DETAIL DENIED. THIS PROCEDURE REQUIRES PRIOR AUTHORIZATION. NO
0539	CLAIM/DETAIL DENIED. EPSDT RELATED SERVICES CLAIM EXCEEDS TOTAL UNITS OF SERVICE PRIOR AUTHORIZED.
0540	HOME HEALTH NURSING VISITS NOT REIMBURSED WHEN PRIVATE DUTY NURSING HAS BEEN AUTHORIZED THROUGH EPSDT SPECIAL
0541	CAST APPLICATION OR REMOVAL HAS BEEN PAID SEPARATE OF SURGERY. PLEASE RESUBMITFOR ADJUSTMENT WITH PAID RA OF
0542	DETAIL DENIED. IMPLANTABLES ARE LIMITED TO TWO UNITS OF SERVICE PER PROCEDURE, PER MEMBER, PER 90 DAYS.
0543	MULTIPLE SURGERIES FOR SAME DATE OF SERVICE MUST BE BILLED ON SAME CLAIM. YOUR CLAIM IS DENIED AND INSTRUCTIONS
0544	CLAIM/DETAIL DENIED. TELEHEALTH SERVICES ARE LIMITED TO 12 PER MEMBER PER 12 MONTHS.
0545	MULTIPLE MEDICAL/SURGICAL PROCEDURES FOR THE SAME DATE OF SERVICE MUST BE BILLED ON SAME CLAIM. FILE AN
0546	CLAIM/DETAIL DENIED. PRESCRIPTION NUMBER REFILL DATE IS GREATER THAN SIX (6) MONTHS OLD.
0547	CLAIM PAYMENT REDUCED. SPEND DOWN DEDUCTED.
0548	CLAIM/DETAIL DENIED. REVENUE CODE 235 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155, 183, AND/OR 185.
0549	CLAIM/DETAIL DENIED. THIS PROCEDURE SHALL NOT BE PAID SEPARATELY WHEN THE GLOBAL SERVICE HAS BEEN REPORTED.
0550	PROCEDURE CODE 00140/D0140 CAN ONLY BE BILLED ALONE OR WITH MONITORED PROCEDURE CODES FOR THE SAME MEMBER,
0551	DISPENSING FEE DEDUCTED. IT WAS PAID WITH DISPENSING OF THE EMERGENCY SUPPLY.
0552	THE STAY DAYS BILLED EXCEEDS THE MAXIMUM NUMBER OF STAY DAYS FOR THIS INPATIENT HOSPITAL STAY.
0553	CLAIM DENIED. DRUG REQUIRES PRIOR AUTHORIZATION OR FIRST LINE THERAPY INITIATED.
0554	THE DATE OF SERVICE AND/OR DOLLAR AMOUNTS ON THE CLAIM AND MEDICARE EOMB DO NOT AGREE. PLEASE VERIFY AND
0555	PLEASE ATTACH THE PART B MEDICARE EXPLANATION OF BENEFITS AND REBILL.
0556	CLAIM/DETAIL DENIED. MEMBER MUST BE AN INPATIENT IN THE NURSING FACILITY.
0557	CLAIM DENIED. SECOND LINE ANTIHISTAMINE NOT PAYABLE WITHIN FIVE DAYS OF A FIRST LINE ANTIHISTAMINE.
0558	CLAIM DETAIL DENIED. H0039 LIMITED TO 32 UNITS PER DAY.
0559	CLAIM DENIED. THIS CLAIM EXCEEDS THE MONTHLY MAXIMUM UNITS FOR THIS NDC.
0560	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.
0567	CLAIM DENIED. NO WAIVER LIABILITY BUCKET FOR MONTH OF SERVICE.
0568	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED
0569	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.
0570	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.
0571	CLAIM DENIED. PRIOR AUTHORIZATION REQUIRED IF 30 DAYS OF THERAPY EXCEEDED DURING A 365 DAY PERIOD.
0572	DETAIL DENIED. LEAD INVESTIGATION IN THE HOME LIMITED TO TWO (2) SERVICES PERSIX MONTHS.
0573	DETAIL DENIED. POST HAZARD ABATE IN HOME LIMITED TO ONE (1) SERVICE PER 12 MONTHS.
0574	CLAIM DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.
0575	REVENUE CODE INVALID FOR DATES OF SERVICE.
0576	ANCILLARY CHARGES NOT ALLOWED WITH PATIENT REVENUE CODES 180 OR 185.
0577	CLAIM DETAIL DENIED. PROCEDURE CODES X0100/H0043 AND X0101/T2016 CANNOT BE BILLED ON THE SAME DATE OF SERVICE FOR
0578	CLAIM DENIED. PRIOR AUTHORIZATION REQUIRED IF 60 DAYS OF THERAPY EXCEEDED DURING A 3 YEAR PERIOD.
0579	CLAIM/DETAIL DENIED. REVENUE CODE 581 LIMITED TO 80 UNITS PER MEMBER PER CALENDAR WEEK (SUNDAY THROUGH
0580	CLAIM/DETAIL DENIED. THE ANNUAL LIMITATION OF \$1000.00 PER MEMBER FOR MINOR HOME ADAPTATIONS HAS BEEN EXCEEDED.
0581	CLAIM/DETAIL DENIED. UNIVERSAL PREVENTION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF EIGHT UNITS PER
0582	CLAIM/DETAIL DENIED. SELECTIVE PREVENTION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 76 UNITS PER MEMBER,
0583	CLAIM/DETAIL DENIED. INDICATED PREVENTION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 108 UNITS PER
0584	CLAIM/DETAIL DENIED. CERTAIN OUTPATIENT SERVICES PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 32 UNITS PER
0585	CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT NON-RESIDENTIAL SERVICES PROCEDURE CODES ARE LIMITED TO A COMBINED
0586	CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT NON-RESIDENTIAL SERVICES PROCEDURE CODES ARE LIMITED TO A COMBINED
0587	CLAIM/DETAIL DENIED. DAY REHABILITATION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 8 UNITS PER MEMBER,
0588	CLAIM/DETAIL DENIED. DAY REHABILITATION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 45 UNITS PER MEMBER,
0589	CLAIM/DETAIL DENIED. SUBSTANCE ABUSE COMMUNITY SUPPORT NOT PAYABLE UNLESS BILLED IN CONJUNTION WITH SUBSTANCE

FOR Code	Description
0590	HOSPITAL OUTPATIENT SERVICES NON-PAYABLE DURING A HOSPITAL INPATIENT STAY.
0591	CLAIM/DETAIL DENIED. OUTPATIENT THERAPIES INDIVIDUAL, GROUP, AND FAMILY PROCEDURE CODES ARE NOT PAYABLE ON THE
0592	CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT SERVICES NON-RESIDENTIAL AND DAY REHABILITATION PROCEDURE CODES ARE NOT
0593	CLAIM DENIED. THIS PROCEDURE IS NOT PAYABLE UNLESS BILLED IN CONJUNTION WITH WB505, WB516, WB526/90862(UD),
0594	CLAIM DENIED. CLAIM EXCEEDS 140 DAY ACID/PEPTIC THERAPY LIMITATION.
0596	CLAIM DETAIL DENIED. OFFICE VISITS NOT ALLOWED WITHIN 10 DAYS FOLLOWING A SURGICAL PROCEDURE.
0597	CLAIM/DETAIL DENIED. THIS PROCEDURE IS NOT PAYABLE AFTER THE DATE OF DELIVERY.
0598	CLAIM DETAIL DENIED. ONLY ONE 'E AND M' CODE ALLOWED PER DATE OF SERVICE.
0599	CLAIM PENDING REVIEW OF HISTORY.
0600	EYE EXAM LIMITED TO OPTOMETRIST.
0600	ONLY 3 FOLLOW UP EXAMS ARE ALLOWED PER 6 MONTHS.
0602	CLAIM DENIED. LIMIT 2 ROUTINE ORTHODONTICS PER MEMBER PER 12 MONTHS
0603	CLAIM DENIED. EACH MEMBER ALLOWED ONE FULL MOUTH RADIOGRAPHY EVERY 2 YEARS PER PROVIDER.
0604	NOT MORE THAN TWO (2) COMPONENT TESTS OF A CBC ARE ALLOWED PER MEMBER ON THE SAME DATE OF SERVICE.
0605	ONLY FOUR MENTAL HEALTH/SUBSTANCE ABUSE PROCEDURES ALLOWED PER YEAR, PER PROVIDER, PER MEMBER.
0606	PIN RETENTION CAN ONLY BE BILLED ALONE OR WITH MONITORED PROCEDURE CODES FOR THE SAME MEMBER, SAME PROVIDER,
0607	EACH MEMBER ALLOWED 4 SINGLE BITEWING X-RAYS PER 12 MONTHS PER PROVIDER.
0608	CLAIM DENIED. THIS SERVICE IS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER CALENDAR MONTH.
0609	CLAIM DENIED. ONE DENTAL PROPHYLAXIS/FLOURIDE TREATMENT PER MEMBER PER 12 MONTH PERIOD.
0610	CLAIM DENIED. EACH MEMBER ALLOWED ONE UPPER TRANSITIONAL APPLIANCE PER 12 MONTHS.
0611	MEMBER ALLOWED THREE TRANSITIONAL APPLIANCE REPAIRS PER 12 MONTHS.
0612	ONLY 9 UNITS (ADULT DAY HABILITATION) ALLOWED PER DATE OF SERVICE PER MEMBER.
0613	RESIDENTIAL RESPITE DAILY SERVICE ALLOWED FOR ONLY 30 CONSECUTIVE DAYS.
0614	MEMBER ALLOWED ONLY 30 CONSECUTIVE DAY OF IN-HOME RESPITE DAILY SERVICE.
0615	MAXIMUM OF 40 DAYS RESIDENTIAL RESPITE COMBINING DAILY AND HOURLY SERVICES PER MEMBER PER CALENDAR YEAR.
0616	MAXIMUM OF 60 DAYS IN-HOME RESPITE ALLOWED COMBINING DAILY AND HOURLY SERVICES PER MEMBER PER CALENDAR YEAR.
0617	MEMBER ALLOWED 1 INITIAL OFFICE VISIT WITH COMPLETE DIAGNOSIS PER 9 MONTHS.
0618	ONLY ONE DELIVERY ALLOWED PER MEMBER/9 MOS.
0619	MEMBER ALLOWED POST-PARTUM CARE 2 TIMES PER YEAR.
0620	CLAIM DENIED. MAXIMUM DAILY DOSE EXCEEDED - PRIOR AUTHORIZATION REQUIRED.
0621	DETAIL DENIED. MAXIMUM DOLLAR AMOUNT FOR COMMUNITY BASED SERVICES RESPITE SERVICE HAS BEEN EXCEEDED.
0622	DETAIL DENIED. ANNUAL LIMIT OF \$500.00 FOR MINOR HOME ADAPTIONS.
0623	MEMBER ALLOWED 14 SINGLE INTRAORAL PERIAPICAL RADIOGRAPHS PER 12 MOS PER PROVIDER.
0624	CLAIM DENIED. THIS PROCEDURE ALLOWED ONE PER DOS PER TOOTH PER PROVIDER.
0625	CLAIM DENIED/MEMBER ALLOWED 3 REPAIRS INCLUDING REPLACEMENTS OF ONE TOOTH PER 12 MONTHS.
0626	CLAIM DENIED. ONLY 14 DAYS SERVICE ALLOWED PER ADMISSION PER MEMBER.
0627	CLAIM DENIED. MEMBER ALLOWED 3 REPAIRS TO BROKEN DENTURES PER 12 MONTHS.
0629	MEMBER ALLOWED 1 LOWER TRANSITIONAL APPLIANCE PER 12 MONTHS.
0631	MEMBERS ARE LIMITED TO ONE DENTURE RELINING PER 12 MONTHS.
0632	FULL MOUTH DEBRIDEMENT IS ALLOWED ONCE PER MEMBER PER PREGNANCY.
0633	CLAIM DENIED. BRAND NECESSARY PRIOR AUTHORIZATION REQUIRED. NO MATCHING BRAND NECESSARY PRIOR AUTHORIZATION
0634	MAXIMUM \$300.00 ALLOWED PER MONTH/MEMBER FOR TANK OXYGEN.
0635	AIS/MR DAILY CODE LIMITED TO ONE UNIT PER DATE OF SERVICE PER MEMBER.
0636	PROFESSIONAL FEE FOR DISPENSING INITIAL PAIR OF EYEGLASSES ALLOW ONE / 12 MOS /MEMBER.
0637	CLAIM DENIED. MEMBER LIMITED TO 3 FETAL TESTS/12 MONTHS. IF UNUSUAL CIRCUMSTANCES, SEND CLAIM DOCUMENTATION TO
0638	ANNUAL FAMILY PLANNING VISITS ARE LIMITED TO ONE PER MEMBER PER 9 MONTHS PER CLINIC.
0640	THIS DETAIL WAS MANUALLY PRICED AFTER REVIEW BY CONSULTANTS.
0641	PRIOR AUTHORIZATION DOES NOT MATCH FOR THIS CLAIM/DETAIL.
0642	THIS PROCEDURE IS LIMITED TO ONE PER 12 MONTHS PER MEMBER PER PROVIDER.
0644	MEMBERS ARE LIMITED TO ONE (1) OPTHAMOLOGICAL EXAMINATION PER PROVIDER PER 12 MONTHS.
0645	NEW PATIENT HOME MEDICAL SERVICES LIMITED TO ONE PER MEMBER PER PROVIDER PER 12 MONTHS.
0646	ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO ONE PER MEMBER PER PROVIDER PER 12 MONTHS.
0648	MEMBER ARE LMTD ON INITIAL PREVENTATIVE CARE VISITS TO 1 PER PROV PER 12 MONTHS.
0649	MEMBER LMTD 1 INITIAL PREVENTATIVE CARE VISITS TO 1 PER PROV PER 12 MONTHS. MEMBER LMTD 1 INITIAL OPTHALMOLOGICAL SERVICE PER PROV PER 12 MONTHS.
0650	
0030	ROUTINE NEWBORN CARE IS PAYABLE ONLY ONCE PER INFANT.

EOB Code	Description
0652	CLAIM DENIED. BIFOCAL OR SINGLE VISION LENSES ARE LIMITED TO FOUR PER 12 MONTHS.
0653	CLAIM/DETAIL DENIED. A PRESCRIPTION CAN ONLY BE BILLED 6 TIMES.
0654	MEMBER ALLOWED FILLINGS FOR UP TO FIVE SURFACES PER TOOTH PER DOS PER PROVIDER.
0655	MAXIMUM OF 14 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER.
0656	MAXIMUM OF 15 NON-HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER CALENDAR YEAR.
0657	MAXIMUM OF 45 HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER CALENDAR YEAR.
0658	MAXIMUM OF 15 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER.
0659	MAXIMUM OF 30 CONSECUTIVE RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER.
0660	MAXIMUM OF 45 RESERVE DAYS PER MEMBER PER PROVIDER PER CALENDAR YEAR.
0661	CLAIM DENIED. READMISSION WITHIN 14 DAYS OF LAST DISCHARGE DATE/THROUGH DATE. PLEASE RESUBMIT WITH
0662	A MAXIMUM OF 14 INPATIENT HOSPITAL DAYS PER ADMISSION AND READMISSION PER MEMBER.
0665	VENIPUNCTURE/CATHETERIZATION PROCEDURES 80020,80022,80023, 80024,36415 NOT ALLOWED SAME DOS/MEMBER/PROVIDER.
0666	CLAIM/DETAIL DENIED. PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED OR NON-MICROSCOPY LAB CODE.
0667	THIS PROCEDURE IS LIMITED TO ONE SERVICE PER MEMBER PER SAME DATE OF SERVICE.
0668	DAY CARE SERVICES ARE LIMITED TO NO MORE THAN 2 UNITS OF SERVICE PER DATE OF SERVICE.
0669	DAYS REDUCED, A MAXIMUM OF 14 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER,PER PROVIDER.
0670	DAYS REDUCED, A MAXIMUM OF 15 NON-HOSPITAL RESERVE DAYS ALLOWED PER MEMBER,PER PROVIDER,PER CALENDAR YEAR.
0671	CLAIM/DETAIL DENIED. MEDICAID WILL PAY FOR ONLY ONE CARDIAC CATHETER PROCEDURE PER DAY.
0673	CLAIM DENIED. CPT LEVEL CODE MISSING OR INVALID.
0674	PROCEDURE CODE V5020 IS LIMITED TO THREE PER MEMBER PER PROVIDER PER SIX MONTHS.
0675	CLAIM DETAIL DENIED. PROCEDURE CODE W0030 IS LIMITED TO ONE UNIT PER MEMBER, PER PROVIDER, PER 60 DAYS.
0676	PROCEDURE W0030/V5011 CAN ONLY BE PERFORMED 150 TO 210 DAYS 5 TO 7 MONTHS AFTER PERFORMING PROCEDURE V5090.
0677	PROCEDURE CODE LIMITED TO ONE PER 60 DAYS.
0678	MEMBERS ARE LIMITED TO A MAXIMUM OF 10 MONTHLY STABILIZATION VISITS DURING PHASE I TREATMENT CONTACT DMS FOR
0679	CLAIM/DETAIL DENIED. ONLY ONE HANDS PROCEDURE CODE ALLOWED PER MEMBER PER DATE OF SERVICE.
0680	FAMILY AND/OR GROUP PSYCHOTHERAPY LMTD TO ONE PER DATE OF SERVICE.
0681	CLAIM DENIED. THIS HOSPITALIZATION IS RELATED TO A PREVIOUSLY PAID ADMISSION.
0682	CLAIM DENIED. REIMBURSEMENT CANNOT EXCEED A MAXIMUM OF 14 DAYS PER ADMISSION.
0683	MODEL WAIVER MEMBERS ARE LIMITED TO 16 HOURS OF NURSING/ RESPIRATORY SERVICES PER DATE OF SERVICE.
0684	MODEL WAIVER RESPIRATORY SERVICES ARE LIMITED TO ONE UNIT PER MEMBER PER DATE OF SERVICE.
0685	CLAIM/DETAIL DENIED. A HOSPICE SERVICE HAS BEEN PAID FOR SAME MEMBER/SAME DATE(S) OF SERVICE.
0686	CLAIM/DETAIL DENIED. HOSPICE RESPITE SERVICES ARE LIMITED TO FIVE CONSECUTIVE DAYS PER MEMBER.
0687	UNITS BILLED EXCEED MAXIMUM FOR THIS PRIOR AUTHORIZATION.
0688	MODEL WAIVER DOLLAR LIMIT HAS BEEN MET.
0689	MEMBERS ARE LIMITED TO A MAXIMUM OF 365 ORAL CONTRACEPTIVE UNITS PER 12 MONTH PERIOD.
0690	CLAIM DENIED. TARGETED CASE MANAGEMENT SERVICES ARE LIMITED TO 1 PER CALENDAR MONTH, PER MEMBER.
0691	CLAIM/DETAIL DENIED. CLIA ID MISSING OR INVALID.
0692	CLAIM/DETAIL DENIED. PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED LAB CODE.
0693	COMPREHENSIVE ORTHODONTIC EXAM LIMITED TO ONE PER MEMBER PER 12 MONTHS.
0694	COMPREHENSIVE ORTHODONTIC EXAM LIMITED TO TWO (2) PER MEMBER PER LIFETIME.
0695	MEMBERS ARE LIMITED TO A MAXIMUM OF 24 MONTHLY RETENTION VISITS PER LIFETIME.
0696	CLAIM/DETAIL DENIED. PROFESSIONAL COMPONENT CHARGES MUST BE BILLED ON HCFA-1500.
0697	MEMBERS ARE LIMITED TO ONE RETENTION VISIT PER 30 DAYS.
0698	MEMBERS ARE LIMITED TO A MAXIMUM OF 10 POST TREATMENT STABILIZATION VISITS PER LIFETIME.
0699	CLAIM/DETAIL DENIED. PROCEDURE CODE T2022 IS LIMITED TO \$260.00 IN
0700	CLINIC PROVIDER IS INELIGIBLE FOR THIS CATEGORY OF SERVICE.
0701	CLAIM DENIED. BED RESERVE REVENUE CODES FOR MENTAL HOSPITAL AND ACUTE PSYCHIATRIC BED ARE LIMITED TO A
0702	CLAIM DENIED. BED RESERVE/OTHER REVENUE CODE IS LIMITED TO A TOTAL OF 21 UNITS PER CALENDAR 6 MONTHS PER MEMBER,
0703	CLAIM DENIED. BED RESERVE/ACUTE REVENUE CODE IS LIMITED TO A TOTAL OF 14 UNITS PER CALENDAR YEAR, PER MEMBER, PER
0704	CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY CLAIMS ARE LIMITED TO 30 CONSECUTIVE BED RESERVE DAYS PER
0705	NEW PATIENT OPHTHALMOLOGICAL SERVICES LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS/THREE YEARS.
0706	NEW PATIENT OFFICE OR OUTPATIENT SERVICES LIMITED TO ONE PER MEMBER, PER PRO VIDER, PER 36 MONTHS/THREE YEARS.
0707	NEW PATIENT HOME MEDICAL SERVICES LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS/THREE YEARS.
0708	NEW PATIENT PREVENTATIVE CARE VISITS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS/THREE YEARS.
0709	CLAIM/DETAIL DENIED. PROCEDURE CODE 70320 LIMITED TO ONE PER YEAR, PER MEMBER, PER PROVIDER.

EOB Code	Description
0710	CLAIM/DETAIL DENIED. ONLY ONE (1) CHEMOTHERAPY ADMIN CODE IS PAYABLE ON THE SAME DATE OF SERVICE. IF QUESTIONS,
0711	PROVIDER NOT APPROVED FOR ELECTRONIC BILLING SUBMIT MAP 380 PROVIDER AGREEMENT FORM.
0712	CLAIM/DETAIL DENIED. PROCEDURE CODE T2022 IS LIMITED TO \$265.00 PER CALENDAR MONTH.
0713	DELIVERY, ROUTINE NEWBORN CARE, CIRCUMCISION ARE LIMITED TO ONE EACH PER MEMBER PER DATE
0715	CLAIM DENIED. PROCEDURE CODE X0064 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER, PER MEMBER, PER TWO YEARS.
0716	CLAIM DENIED. PROCEDURE CODE X0074 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER, PER MEMBER, PER TWO YEARS.
0717	CLAIM DENIED. PROCEDURE CODE X0074 EIMITED TO ONE ONT OF SERVICE PER PROVIDER, PER MEMBER, PER TWO
0717	CLAIM DENIED. PROCEDURE CODE X0076/T2022 LIMITED TO A FOTAL OF 70 ONITS OF SERVICE PER PROVIDER, PER MEMBER, PER CALENDAR
0718	CLAIM DENIED. A MAXIMUM OF 60 RESPITE DAYS (COMBINING DAILY AND HOURLY SERVICES) ALLOWED PER PROVIDER, PER
0719	CLAIM/DETAIL DENIED. BUCCAL AND FACIAL TOOTH SURFACES NOR OCCLUSAL AND INCISAL TOOTH SURFACES NOT ALLOWED FOR
0/22	
0722	SAME MEMBER, SAME PROVIDER, SAME DATE OF SERVICE
0723	CLAIM/DETAIL DENIED. ONLY FOUR TOOTH SURFACES ALLOWED PER MEMBER, PER PROVIDER, PER DATE OF SERVICE, PER TOOTH
0724	CLAIM DETAIL DENIED. HOME MODIFICATIONS ARE LIMITED TO \$1000.00 IN PAYMENTS PERSIX MONTHS.
0725	INDIVIDUAL PSYCHOTHERAPY IS LIMITED TO 12 UNITS OF SERVICE PER DAY, PER MEMBER, PER PROVIDER.
0726	CLAIM/DETAIL DENIED. CEPHALOMETRIC X-RAY LIMITED TO ONE PER MEMBER, PER PROVIDER, EVERY TWO YEARS.
0727	CLAIM/DETAIL DENIED. DIALYSIS TRAINING LIMITED TO ONE (1) PER MEMBER, PER LIFETIME.
0728	GINGIVECTOMY PROCEDURE IS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER TOOTH NUMBER PER 12 MONTHS.
0729	PIN RETENTION THERAPY TREATMENT IS LIMITED TO TWO PER MEMBER PER PERMANENT MOLAR PER LIFETIME.
0730	PROCEDURE CODE 07880/D7880 LIMITED TO ONE PER LIFETIME PER MEMBER.
0731	MEMBERS ARE LIMITED TO ONE RELINING OF THE LOWER DENTURE PER 12 MONTHS.
0732	ALVEOPLASTY PROCEDURE CODES ARE LIMITED TO ANY COMBINATION OF THESE PROCEDURES WITH ONLY ONE PER QUADRANT,
0733	PROCEDURES ARE LIMITED TO ANY COMBINATION OF THESE PROCEDURES WITH ONLY ONE EACH PER QUADRANT, PER MEMBER,
0734	CLAIM/DETAIL DENIED.PROCEDURE IS NOT ALLOWED TO THE SAME TOOTH ON THE SAME DATE OF SERVICE AS A SEALANT.
0735	CLAIM/DETAIL DENIED. SYRINGES LIMITED TO 125 UNITS PER 26 DAYS, PER MEMBER.
0736	CLAIM/DETAIL DENIED. VACCINE ADMINISTRATION LIMITED TO (3) PER MEMBER, PER PROVIDER, PER DATE OF SERVICE.
0737	CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO ONE PER TOOTH PER FOUR YEARS PER MEMBER.
0738	CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO THREE PER TOOTH PER LIFETIME PER MEMBER.
0739	CLAIM/DETAIL DENIED. SEALANTS ARE NOT ALLOWED TO A TOOTH THAT HAS RECEIVED AN OCCLUSAL FILLING.
0740	CLAIM/DETAIL DENIED. ONLY ONE UNIT OF SERVICE ALLOWED FOR THIS DENTAL PROCEDURE PER PRIOR AUTHORIZATION.
0741	CLAIM DENIED. MEMBER LIMITED TO 2 DIAGNOSTIC ULTRASOUNDS PER 9 MONTHS. MEDICAL NECESSITY MUST SUPPORT UNUSUAL
	CIRCUMSTANCES. DIAGNOSIS CODE MUST INDICATEMED
0742	DETAIL DENIED. INTRAORAL COMPLETE SERIES LIMITED TO ONE UNIT PER MEMBER, PER PROVIDER, PER 12 MONTHS.
0743	GINGIVECTOMY LIMITED TO 1 UNIT PER TOOTH, PER 12 MONTHS, PER MEMBER, PER PROVIDER.
0744	CLAIM/DETAIL DENIED. SCHOOL-BASED HEALTH SERVICES ARE LIMITED TO 40 UNITS OF SERVICE PER DATE OF SERVICE. PLEASE
0745	CLAIM/DETAIL DENIED. PROCEDURE CODE X0058 CANNOT BE BILLED BY A SCHOOL BASED PROVIDER AND A COMMUNITY MENTAL
0746	REVENUE/PROCEDURE CODE INVALID FOR PROVIDER TYPE.
0747	CLAIM DETAIL DENIED. PROCEDURE CODES X0079/H0039 AND X0098/97537, (ANY COMBINATION) ARE LIMITED TO FORTY HOURS
0748	REVENUE/PROCEDURE CODE INVALID FOR PLACE OF SERVICE.
0749	CLAIM DETAIL DENIED. RESPITE CARE IS LIMITED TO 168 HOURS PER SIX MONTHS.
0750	DRUG/DRUG INTERACTION.
0751	REVENUE/PROCEDURE CODE INVALID FOR DATE OF SERVICE.
0752	REVENUE CODE MISSING/INVALID.
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0753	INVALID REVENUE CODE. CHARGES NOT ALLOWED.
0754	EARLY REFILL.
0755	NON-REIMBURSABLE FOR THIS PROVIDER TYPE/DOS. EFFECTIVE FOR DOS 10/01/90 AND AFTER, DRUGS MUST BE BILLED BY
0756	CLIA ID MISSING OR INVALID. CHARGES MOVED TO NON-COVERED.
0757	CHARGES MOVED TO NON-COVERED. RTSUP CAN ONLY BE REIMBURSED WHEN CHARGES FOR RTARE BILLED FOR THE SAME DATES
0758	PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED LAB CODE. CHARGES MOVED TO NON-COVERED.
0759	PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED OR NON-MICROSCOPY LAB CODE. CHARGES MOVED TO NON-COVERED.
0760	INFERRED DRUG/DISEASE PRECAUTION.
0761	DRUG/AGE PRECAUTION.
0762	MEDICAL CONDITION ALERT.
0763	SERVICES RENDERED DO NOT MEET DMS CRITERIA
0764	DIAGNOSIS AND DESCRIPTION OF TREATMENT ARE REQUIRED FOR SERVICES RENDERED.
0765	THERAPEUTIC DUPLICATION.

FOB Code	Description
0766	REVENUE CODE PROCEDURE CODE COMBINATION INVALID. CHARGES MOVED TO NON-COVERED.
0767	INGREDIENT DUPLICATION.
0768	ALCOHOL PRECAUTION.
0769	BREAST FEEDING PRECAUTION.
0770	DRUG/FOOD INTERACTION.
0771	DRUG/LAB CONFLICT.
0772	CALL HELP DESK (1-800-807-1232).
0773	INVALID DUR CONFLICT CODE.
0774	INVALID DUR INTERVENTION CODE.
0775	INVALID DUR OUTCOME CODE.
0777	CLAIM DENIED. PHARMACY CLAIMS MUST BE BILLED THROUGH POS.
0778	VARIANCE LIMIT MET. CLAIM PENDING REVIEW.
0781	CLAIM/DETAIL DENIED. THE MEMBER'S ANNUAL SPEECH THERAPY VISIT LIMIT
0782	CLAIM/DETAIL DENIED. THE MEMBER'S ANNUAL PHYSICAL THERAPY VISIT LIMIT
0783	FULL MOUTH DEBRIDEMENT NOT ALLOWED ON SAME DATE OF SERVICE AS PROPHY OR
0784	PROPHY OR PERIODONTAL SCALING AND ROOT PLANNING NOT ALLOWED ON SAME DATE
0785	CLAIM/DETAIL DENIED. ONLY ONE DENTAL VISIT ALLOWED PER MEMBER PER
0786	CLAIM/DETAIL DENIED. CAST PROCEDURES ARE LIMITED TO TWO PER 90 DAYS PER
0788	CLAIM/DETAIL DENIED. ADULT DAY TRAINING IS LIMITED TO FIVE (5) DAYS PER
0789	CLAIM/DETAIL DENIED. ADULT DAY TRAINING ON-SITE IS LIMITED TO EIGHT (8)
0790	CLAIM/DETAIL DENIED. ADULT DAY TRAINING IS LIMITED TO 255 DAYS PER
0791	CLAIM DETAIL DENIED. REVENUE CODE 580 IS LIMITED TO 45 UNITS (HOURS) PER WEEK (SUNDAY THROUGH SATURDAY).
0792	CLAIM DETAIL DENIED. ONLY ONE OBSTETRICAL VISIT ALLOWED IN AN EIGHT WEEK PERIOD.
0793	CLAIM DETAIL DENIED. ONLY ONE COMPREHENSIVE VISIT ALLOWED EVERY 50 WEEKS.
0794	CLAIM/DETAIL DENIED. EPIDURAL INJECTIONS FOR CONTROL OF PAIN SHALL BE LIMITED TO 3 INJECTIONS PER 6 MONTHS PER
0795	CLAIM/DETAIL REQUIRES PRIOR AUTHORIZATION. THE MONTHLY (CALENDAR MONTH) LIMITATION FOR THIS PROCEDURE CODE HAS
0796	CLAIM/DETAIL REQUIRES PRIOR AUTHORIZATION. THE ANNUAL (CALENDAR YEAR) LIMITATION FOR THIS PROCEDURE CODE HAS
0797	THE ANNUAL MAXIMUM FOR THIS SERVICE HAS BEEN EXCEEDED. THE ALLOWED
0798	PROCEDURE CODE XZ299 IS LIMITED TO \$150.00 PER CALENDAR MONTH PER MEMBER, PER PROVIDER.
0799	REVENUE CODE 270 CANNOT EXCEED \$2,000 BILLED AMOUNT PER MONTH. PLEASE RESUBMIT WITH ITEMIZED INVOICE FOR
0800	CLAIM DENIED. PROCEDURE CODES X0074 AND X0075 NOT PAYABLE ON SAME DATE OF SERVICE AS X0076.
0801	CLAIM DENIED. PROCEDURE CODE X0076 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X0074 OR X0075.
0802	EVALUATION CODES DISALLOWED BY SAME PROVIDER FOR SAME MEMBER ON THE SAME DATE OF SERVICE AS PROCEDURES
0803	MEMBER APPLIED INCOME NOT CURRENT FOR DOS - RECYCLE FOR EDIT 271.
0808	MONTHLY DIALYSIS PROCEDURE CODES ARE NOT REIMBURSEABLE FOR THE SAME OR OVERLAPPING DATE OF SERVICE AS DAILY
0809	DATE PRESCRIBED IS MISSING
0810	HEMODIALYSIS PROCEDURE CODES ARE NOT REIMBURSABLE FOR THE SAME OR OVERLAPPING DATES OF SERVICE AS EVALUATION
0811	NDC IS MISSING
0812	ADDITIONAL SURGICAL PROCEDURES ARE NOT PAYABLE ON SAME DATE OF SERVICE BY SAME PROVIDER FOR SAME MEMBER WHEN
0813	QUANTITY DISPENSED IS INVALID.
0814	MEMBER ID NUMBER IS INVALID.
0815	CLAIM DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE ON THE SAME DATE OF SERVICE AS COMMUNITY RESIDENTIAL
0816	CAST REMOVAL OR REPAIR HAS BEEN PAID WITH APPLICATION OF CAST. IF UNRELATED PROCEDURES, SEND CLAIM WITH
0818	VENIPUNCTURE OR ARTERIAL PUNCTURE IS NOT ALLOWED ON THE SAME DATE OF SERVICE AS OTHER MONITORED PROCEDURES.
0820	BILLING OR REFERRING KENPAC PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PHYSICIAN/CLINIC FOR DATE(S) BILLED.
0821	CLAIM DETAIL DENIED. LIMITATION EXCEEDED, PRIOR AUTHORIZATION REQUIRED.
0822	X-RAY PROCEDURE NOT ALLOWED WITHIN 12 MONTHS OF INTRAORAL COMPLETE SERIES.
0824	DETAIL DENIED. PROCEDURE CODE 08670 NOT PAYABLE WITHIN 24 MONTHS OF CERTAIN OTHER PROCEDURE CODES IF BILLED FOR
0825	DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE WITHIN 24 MONTHS OF ORTHODONTIC TREATMENT IF BILLED FOR THE SAME
0826	PROCEDURE CODE 09110/D9110 NOT PAYABLE IF PAYMENT HAS BEEN MADE FOR OTHER DENTAL PROCEDURE CODES FOR THE SAME
0827	THIS PROCEDURE CODE IS NOT PAYABLE IF PAYMENT HAS BEEN MADE FOR PROCEDURE CODE 09110/D9110 FOR THE SAME DATE OF
0828	CLAIM/DETAIL DENIED. THIS REVENUE CODE IS NOT PAYABLE FOR THIS PROVIDER SPECIALTY CODE.
0829	CLAIM/DETAIL DENIED. PROVIDER NOT ELIGIBLE TO RECEIVE PAYMENT FOR SERVICES PROVIDED TO KCHIP PHASE III MEMBERS.
0830	CLAIM DENIED. NO DRG FOUND.
0831	CLAIM DENIED. DRG CANNOT USE DIAGNOSIS CODE.

EOB Code	Description
0832	CLAIM DENIED. DRG CRITERIA NOT MET.
0833	CLAIM DENIED. DRG INVALID AGE.
0834	CLAIM DENIED. DRG INVALID SEX.
0835	CLAIM DENIED. DRG INVALID DISCHARGE STATUS.
0836	CLAIM DENIED. DRG INVALID PRINCIPLE DIAGNOSIS.
0837	CLAIM DENIED. DRG DENY 469 THROUGH 470.
0838	PROCEDURE CODE T2033 LIMITED TO ONE UNIT PER DAY PER MEMBER
0839	RESERVED FOR DRG
0840	PROCEDURE CODE HAS BEEN REBUNDLED.
0841	BYPASS INDICATOR, GMIS INFORMATIONAL ONLY.
0842	PROCEDURE CODE IS MUTUALLY EXCLUSIVE.
0843	PROCEDURE CODE IS INCIDENTAL.
0844	PROCEDURE CODE IS NOT INDICATED FOR SEPARATE REIMBURSEMENT.
0845	VISIT IS WITHIN ONE DAY PRE OP RANGE.
0846	PROCEDURE CODE INCLUDES UNILATERAL AND BILATERAL PERFORMANCE.
0847	PROCEDURE IS A BILATERAL OR DUPLICATE
0848	PLEASE PAY SPECIFIED PROCEDURE CODES.
0849	PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON.
0850	PROCEDURE CODE IS INVALID FOR PATIENTS AGE.
0851	PROCEDURE CODE IS INVALID FOR PATIENTS SEX.
0852	INAPPROPRIATE PROCEDURE CODE FOR MEMBER'S AGE.
0853	PEDIATRIC PROCEDURE AGE SHOULD BE 1 TO 17 YEARS
0854	MATERNITY PROCEDURE AGE SHOULD BE 12 - 55 YEARS.
0855	KYCONV-DESCRIPTION NOT FOUND
0856	PROCEDURE IS INVALID FOR THE MEMBER'S GENDER.
0857	PROCEDURE NOT INDICATED FOR A FEMALE
0858	CLAIM DENIED. COSMETIC PROCEDURE.
0859	CLAIM DENIED. DUPLICATE PROCEDURE.
0860	CLAIM DENIED. EXPERMENTAL PROCEDURE.
0861	CLAIM DENIED. OBSOLETE PROCEDURE.
0863	PROCEDURE CODES DOES NOT REQUIRE AN ASSTANT SURGEON
0864	PROCEDURE CODE IS INVALID FOR LOCATION.
0865	PROCEDURE CODE NEEDS TO BE REPLACED.
0866	PROCEDURE NEEDS TO BE REPLACED FOR SURFACES BILLED.
0867	PROCEDURE CODE NEEDS TO BE REPLACED FOR SURFACES BILLED.
0868	CLAIM/DETAIL DENIED. PURCHASE OF PROCEDURE CODES E0607 AND E2100 IS LIMITED TOONE PER FOUR YEARS.
0871	CLAIM/DETAIL DENIED. HEARING AID FITTING/CHECKING LIMITED TO 6 PER CALENDAR YEAR.
0872	CLAIM/DETAIL DENIED. HEARING AIDS ARE LIMITED TO \$1200.00 PER EAR, PER 36 MONTHS
0873	CLAIM/DETAIL DENIED. EYEWARE LIMITATION OF \$400.00 PER CALENDAR YEAR HAS
0874	CLAIM/DETAIL DENIED. EYEWARE LIMITATION OF \$200.00 PER CALENDAR YEAR HAS
0875	CLAIM/DETAIL DENIED. PROSTHETIC DEVICE LIMITATION OF \$1500.00 PER
0876	CLAIM/DETAIL DENIED. HEARING AIDS ARE LIMITED TO \$800.00 PER EAR, PER
0877	CLAIM/DETAIL DENIED. CHILDREN'S DENTAL PROPHYLAXIS AND FLOURIDE
0878	CLAIM/DETAIL DENIED. THE 12-MONTH LIMIT FOR DENTAL PROPHYLAXIS
0879	PROCEDURE REQUIRES DOCUMENTATION
0880	CLAIM DENIED. PROCEDURE CODE IS FOR PATIENTS UP TO AGE 14
0881	CLAIM DENIED. PROCEDURE CODE IS FOR PATIENTS OVER AGE 14.
0882	CLAIM DENIED. COSMETIC PROCEDURE NOT PAYABLE BY MEDICAID
0883	CLAIM DENIED. DUPLICATE PROCEDURE HAS BEEN PAID.
0884	CLAIM DENIED PROCEDURE IS CONSIDERED EXPERIMENTAL
0885	CLAIM DENIED. PROCEDURE IS CONSIDERED OBSOLETE.
0886	INAPPROPRIATE PROCEDURE CODE BILLED.
0888	VISIT IS WITHIN THE POST-OP RANGE.
0889	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS NOT PAYABLE IF BILLED WITH A SUBSTANCE ABUSE DIAGNOSIS CODE.
0890	CLAIM/DETAIL DENIED. THIS PROCEDURE IS NOT PAYABLE IF BILLED WITHOUT ONE OF THE DESIGNATED PREGNANCY DIAGNOSIS
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FOB Code	Description
0891	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE IF BILLED WITHOUT ONE OF THE DESIGNATED SUBSTANCE ABUSE
0893	UNITS OF SERVICE GREATER THAN THE REMAINING PRIOR AUTHORIZED AMOUNT.
0894	DETAIL DENIED. THE PRIOR AUTHORIZED AMOUNT FOR THIS PROCEDURE HAS BEEN MET.
0896	CLAIM HAS FAILED MORE THAN 24 ERROR CODES. PLEASE CORRECT AND RESUBMIT.
0897	CLAIM DENIED TO PROVIDER NUMBER 99999997 FOR REBATCH OR RETURN REASONS.
0898	TOO MANY CLAIMS IN A CYCLE.
0899	DENIED PER PROVIDER REQUEST.
0900	THE RX NUMBER MUST BE COMPLETED TO PROCESS YOUR CLAIM. PLEASE COMPLETE AND RESUBMIT YOUR CLAIM.
0901	DRUG QUANTITY IS REQUIRED. COMPLETE THE MISSING INFORMATION AND RESUBMIT YOUR CLAIM.
0902	CLAIM DENIED. DRUG QUANTITY BILLED FOR ESTABLISHED MINIMUM/ MAXIMUM QUANTITIES.
0903	CLAIM DENIED. DRUG DAYS SUPPLY MISSING OR INVALID.
0904	CLAIM DENIED. NDC IS RATED DESI FOR CLAIM DATE OF SERVICE.
0905	CLAIM CREDIT QUANTITY MUST BE EQUAL TO OR LOWER THAN ORIGINAL CLAIM QUANTITY, PLEASE RESUBMIT.
0906	PRESCRIBING PROVIDER'S LICENSE NUMBER MISSING INVALID OR NOT ON KY MEDICAID FILE.
0907	CLAIM DENIED. NDC IS TERMINATED OR OBSOLETE.
0908	CLAIM\DETAIL IS DENIED. THE MEMBER IS IN A NURSING FACILITY ON THE DATE OF SERVICE.
0909	CLAIM DETAIL DENIED. ANCILLARY SERVICES NOT AUTHORIZED BY THE PRO.
0910	CLAIM DENIED. SUBMITTED LEVEL OF CARE SERVICES NOT AUTHORIZED BY THE PRO.
0911	MODIFIER INVALID FOR PROCEDURE CODE BILLED.
0912	CLAIM DENIED. OUTPATIENT HOSPITAL CLAIMS FOR MORE THAN 2 DAYS ARE NOT ALLOWED.
0913	CLAIM DENIED. OUTPATIENT HOSPITAL CLAIMS FOR MORE THAN TWO DAYS ARE NOT ALLOWED.
0914	CLAIM DENIED. HEADER COVERED DAYS GREATER THAN THE 14 DAY MAXIMUM ALLOWED.
0915	CLAIM/DETAIL DENIED. THE NON-COVERED AMOUNT CANNOT BE GREATER THAN THE BILLED AMOUNT.
0916	EPSDT SPECIAL SERVICES/SCHOOL BASED HEALTH SERVICES CLAIMS NOT PAYABLE FOR THIS MEMBER.
0917	CLAIM/DETAIL DENIED. SCREENING PROCEDURE CODE INVALID FOR MEMBER'S AGE.
0918	CLAIM/DETAIL DENIED. THE DETAIL DATES OF SERVICE ARE NOT EQUAL TO OR WITHIN THE HEADER DATES OF SERVICE.
0919	DETAIL DENIED. THIS SERVICE IS NOT PAYABLE BEYOND THE BIRTH MONTH OF THE MEMBER'S 21ST BIRTHDAY.
0920	CLAIM DENIED. A PRESCRIPTION CAN ONLY BE BILLED 12 TIMES.
0921	CLAIM DENIED. THIRD PARTY LIABILITY AMOUNT IS EQUAL TO MEDICARE PAID AMOUNT OR GREATER THAN HEADER COINSURANCE
0922	THIS SERVICE WAS NOT PAID BY MEDICARE. MEDICAID PAYMENT CAN ONLY BE MADE FROM A PAID MEDICARE EOMB.
0923	CLAIM DENIED. A NINE-BYTE, ALL-NUMERIC TAX ID-NUMBER MUST BE ENTERED IN THE PATIENT'S ACCOUNT NUMBER FIELD ON THE
0924	CLAIM DENIED. DISPROPORTIONATE SHARE HOSPITAL CLAIMS WHICH SPAN A MEMBER'S 6THBIRTHDAY MUST BE SPLIT BILLED.
0925	CLAIM/DETAIL DENIED. VENIPUNCTURE AND ARTERIAL PUNCTURE NOT ALLOWED ON SAME DATE OF SERVICE AS OTHER
0926	CLAIM/DETAIL DENIED. THIS SERVICE NOT PAYABLE ON THE SAME DATE OF SERVICE AS VENIPUNCTURE AND ARTERIAL PUNCTURE.
0927	CLAIM DENIED. THE CLINIC NUMBER MUST BE ENTERED.
0928	DETAIL DENIED. A VALID 5-DIGIT MODIFIER MUST BE ENTERED.
0929	CLAIM/DETAIL DENIED. ANESTHESIA LIMITED TO ONE PER MEMBER PER PROVIDER PER DATE OF SERVICE.
0930	CLAIM/DETAIL DENIED. MEMBER HAS THIRD PARTY LIABILITY (MEDICARE REPLACEMENT POLICY) COVERAGE ON FILE.
0931	CLAIM DENIED. COMPOUND CODE MISSING OR INVALID.
0932	CLAIM/DETAIL DENIED. ONE DIALYSIS SERVICE ALLOWED PER RECIPIENT, PER PR
0933	CLAIM DENIED. UNIT DOSE INDICATOR MISSING OR INVALID.
0934	CLAIM DENIED DUE TO TRANSITION TO NEW SYSTEM. PLEASE RESUBMIT CLAIM.
0935	DRUG INCOMPATABILITY ALERT.
0936	CLAIM DENIED. MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATE(S) OF SERVICE.
0937	CLAIM DENIED. PRESCRIPTION NUMBER REFILL DATE IS GREATER THAN ONE YEAR OLD.
0938	CLAIM/DETAIL DENIED. MAXIMUM OF TEN NON-HOSPITAL RESERVE DAYS ALLOWED
0939	CLAIM/DETAIL DENIED. MAXIMUM OF 14 HOSPITAL RESERVE DAYS ALLOWED PER CALENDAR YEAR.
0941	CLAIM DENIED. CURRENT PROVIDER LICENSE NOT ON FILE.
0942	CLAIM DENIED. REVENUE CODE 129 IS NOT VALID WITH ANY OTHER ACCOMMODATION REVENUE CODE.
0943	CLAIM/DETAIL DENIED. FRAMES OR COMPONENTS OF FRAMES ARE LIMITED TO 2
0944	LOW DOSE ALERT.
0945	HIGH DOSE ALERT.
0946	LATE REFILL.
0947	MINIMUM DURATION ALERT.
0948	MAXIMUM DURATION ALERT.

FOR Code	Description
0949	DRUG ALLERGY ALERT.
	CLAIM DENIED. THIS SERVICE IS NOT PAYABLE FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY MEMBERS.
0951	THIS SERVICE IS NOT COVERED BY MEDICAID.
0952	REIMBURSEMENT FOR THIS SERVICE IS INCLUDED IN THE TOTAL PAYMENT AMOUNT.
0953	CLAIM DETAIL DENIED. ONLY ONE UNIT OF SERVICE ALLOWED PER MODIFIER.
0954	CLAIM DETAIL DENIED. THE PROCEDURE CODE MODIFIER IS MISSING OR INVALID.
0955	CLAIM/DETAIL DENIED. PROVIDER SPECIALITY INVALID FOR MODIFIER GT.
0956	THIS PROFESSIONAL CANNOT BILL THIS PROCEDURE CODE.
0957	CMHC PROCEDURES X0054 OR X0152 PAYABLE ONLY WHEN BILLED WITH ANOTHER CMHC PROCEDURE CODE
0958	EFFECTIVE WITH DATES OF SERVICE ON OR AFTER 070193, A FIVE- DIGIT MODIFIER MUST BE BILLED ON COMMUNITY MENTAL
0959	PRIOR ADVERSE DRUG REACTION.
0960	THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE ACCOMMODATION REVENUE CODE 100. CHARGES MOVED
0961	THIS REV CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE ACCOMMODATION REVENUE CODE 100. CHARGES MOVED THIS REV CODE IS NOT PAYABLE WHEN BILLED W/ ALL INCLUSIVE REVENUE CODE 101 AND ALL INCLUSIVE ANCILLARY REVENUE CODE
0962	PREGNANCY ALERT.
0963	DRUG/GENDER ALERT.
0964	CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES ARE NOT PAYABLE TO MEMBERS THIS AGE.
0965	CLAIM DENIED. CHILDREN'S TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO MEMBERS OVER AGE 20.
0966	CLAIM DENIED. ADULT TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO MEMBERS UNDER AGE 18.
0967	CLAIM DENIED. REIMBURSEMENT FOR THIS REVENUE CODE IS LIMITED TO TWO UNITS OF SERVICE PER DAY.
0968	CLAIM DENIED. REIMBURSEMENT FOR THIS REVENUE CODE IS LIMITED TO ONE UNIT OF SERVICE PER DAY.
0969	THIS PROCEDURE CODE REQUIRES THE ENTRY OF A VALID QUADRANT CODE IN THE TOOTH NUMBER FIELD.
0970	THIS PROCEDURE REQUIRES THE ENTRY OF A VALID ARCH CODE.
0971	LITER FLOW PER MINUTE AND/OR NUMBER OF HOURS MISSING OR INVALID.
0972	CLAIM DENIED. PROCEDURE CODES FOR MILEAGE, OXYGEN, AND SUPPLIES MUST MATCH THE BASE RATE CATEGORY.
0973	PIN RETENTION THERAPY IS LIMITED TO ONE TOOTH PER DATE OF SERVICE.
0974	DUPLICATE TOOTH NUMBERS ARE NOT ALLOWED ON THE SAME DETAIL FOR GINGIVECTOMY PROCEDURE.
0975	UNITS MUST EQUAL NUMBER OF TEETH PER DETAIL FOR PROCDURE GINGIVECTOMY PROCEDURE.
0976	PIN RETENTION THERAPY IS LIMITED TO PERMANENT MOLARS ONLY.
0977	TYPE OF BILL INVALID FOR PROVIDER TYPE.
0978	CLAIM DENIED. ONLY ONE BASE RATE PROCEDURE CODE ALLOWED PER CLAIM.
0979	CLAIM DENIED. EMERGENCY TRANSPORTATION CLAIMS WITH DATES OF SERVICE ON OR AFTER 7/1/95 MUST BE SUBMITTED ON
0980	COPAY FOR THIS SERVICE IS ADDITIVE. THE COPAY AMOUNT WAS CREDITED TO THE MEMBER'S ANNUAL OUT-OF-POCKET USED
0981	CLAIM DENIED. PAPER BILLING ONLY ALLOWED FOR MEMBERS IN CERTAIN COUNTIES, FOR CERTAIN PROCEDURE CODES, FOR DATES
0982	CLAIM/DETAIL DENIED. VACCINE PROCEDURE CODE MUST BE BILLED USING MODIFIER 26 FOR ADMINISTRATION TO INDICATE
0984	CLAIM DOES NOT INDICATE THAT COINSURANCE, DEDUCTIBLE, OR COPAY AMOUNTS ARE DUE.
0985	DETAIL DENIED. THIS PROCEDURE LIMITED TO TWO UNITS OF SERVICE.
0986	DETAIL DENIED. PROCEDURE CODE A0420 MUST ALSO BE BILLED WHEN AN EXTRA MILEAGE PROCEDURE CODE IS BILLED WITH A
0987	DETAIL DENIED. PROCEDURE CODES A0070 AND A0422 LIMITED TO 1 UNIT OF SERVICE IF BASE RATE INDICATES ONE WAY TRIP.
0988	HEADER MEDICARE ALLOWED AMOUNT IS NOT EQUAL TO THE SUM OF THE DETAIL MEDICARE ALLOWED AMOUNTS.
0989	CLAIM/DETAIL DENIED. RETURN MILEAGE NOT PAYABLE WHEN BILLING FOR ONE WAY TRIP.
0990	DETAIL DENIED. SERVICES NOT PAYABLE BEYOND THE MONTH OF THE MEMBER'S THIRD BIRTHDAY.
0991	KYCONV-DESCRIPTION NOT FOUND
0992	DETAIL DENIED. PROCEDURE CODE INVALID FOR PROVIDER TYPE 13.
0993	CLAIM/DETAIL DENIED. SERVICES NOT PAYABLE ON SAME DATE OF SERVICE AS AIR AMBULANCE.
0994	CLAIM/DETAIL DENIED. MILEAGE PROCEDURE CODES NOT PAYABLE SAME DATE OF SERVICE AS ADDITIONAL PASSENGER PROCEDURE
0996	NUMBER OF STUDENTS IN GROUP MISSING OR INVALID.
0997	CLAIM PAID ZERO DUE TO INVALID PRESCRIBER LICENSE NUMBER. PLEASE RESUBMIT AN ADJUSTMENT WITH CORRECTED VALID
0998	CLAIM TEMPORARILY SUSPENDED UNTIL NEW FEE UPDATE IS IMPLEMENTED.
0999	PENDING FOR REVIEW.
1000	INDIVIDUAL/BILLING PROVIDER(GROUP)/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE.
1001	INDIVIDUAL/BILLING PROVIDER (GROUP)/NPI NUMBER(S) NOT ENROLLED AT SERVICE LOCATION FOR PROGRAM BILLED (HEADER).
1002	COB - PAYER
1003	INDIVIDUAL/BILLING PROVIDER (GROUP)/NPI NUMBER(S) NOT ENROLLED AT SERVICE LOCATION FOR PROGRAM BILLED (HEADER).
1004	CLAIM SUBMITTED WITH INVALID OR NO ICD VERSION.
1005	CLAIM DENIED. CLAIM DOS CANNOT SPAN ICD10 EFFECTIVE DATE.

1005 FACILITY PROV NOT ELIG AT SERVL JOG FOR PROG BILLED 1007 REVENUE CODE SELLED DOES NOT MATCH THE DESIGNATED LEVEL OF TRAUMA CENTERS/HOSPITALS DESIGNATED AS SUCH BY THE STATE 1008 REVENUE CODE BILLED DOES NOT MATCH THE DESIGNATED LEVEL OF TRAUMA FOR ROSPITALIPROVIDER 1009 REQUERED POCUMENTALION AND/OR INVOICE IS MISSING OR DOES NOT SUPPORT TRAUMA TEAM ACTIVATION/RESPONSE. 1010 REVENUE CODE BILLED DOES NOT AMEMBER OF BILLING GROUP. 1011 NITERAL FRIOR 1015 CLAM DENIED. ONE OF THE PROVIDERS SUBMITTED ON YOUR CLAIM IS NOT ENROLLED WITH KY MEDICAID. PLEASE GO TO KY 1016 NOP PRATICIPATING MANUFACTURER 1017 NOP PARTICIPATING MANUFACTURER 1018 NO PRECING SEGMENT FOR LEVEL OF CARE 1019 FACILITY PROVIDER IS NOT ELIGIBLE. 1019 REFERENCE SECOND FOR LEVEL OF CARE 1019 REFERENCE PROVIDER IS NOT ELIGIBLE. 1010 FACILITY PROVIDER IS NOT ELIGIBLE. 1010 FACILITY PROVIDER IS NOT ELIGIBLE. 1010 FACILITY PROVIDER IS NOT ELIGIBLE. 1011 BILLING PROVIDER IS NOT ELIGIBLE. 1012 BILLING PROVIDER IS NOT ELIGIBLE. 1013 BILLING PROVIDER IS NOT ELIGIBLE. 1014 BILLING PROVIDER IS NOT ELIGIBLE. 1015 BILLING PROVIDER IS NOT ELIGIBLE. 1016 BILLING PROVIDER IS NOT ELIGIBLE. 1017 TAXONOMY CODE INVALID FOR PERCENTING PROVIDER IS NOT ELIGIBLE. 1018 BILLING PROVIDER IS NOT ELIGIBLE. 1019 BILLING PROVIDER IS NOT ON THE IS NOT ON	EOB Code	Description
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	1767	CANNOT DETERMINE MEDICAID ID FROM THE NPI. REFERRING PROVIDER1 TAXONOMY IS REQUIRED FOR THIS DENTAL CLAIM.
1769 REFERRING PROVIDER1 NPI/TAXONOMY COMBINATION NOT FOUND FOR THIS DENTAL CLAIM.	1768	REFERRING PROVIDER1 TAXONOMY ON THIS DENTAL CLAIM IS NOT ON FILE.
	1769	REFERRING PROVIDER1 NPI/TAXONOMY COMBINATION NOT FOUND FOR THIS DENTAL CLAIM.

FOR Code	Description
1770	REFERRING PROVIDER1 NPI/TAXONOMY COMBINATION NOT VALID FOR THE DATE OF SERVICEON THIS DENTAL CLAIM.
	REFERRING PROVIDER1 MEDICAID PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE ON THIS DENTAL CLAIM.
1772	THE REFERRING PROVIDER1 ON THIS DENTAL CLAIM IS NOT A VALID ORP MEDICAID PROVIDER TYPE OR IS NOT AN INDIVIDUAL
1773	REFERRING PROVIDER2 NPI IS NOT ON FILE OR NOT VALID FOR THE DATE OF SERVICE ONTHIS DENTAL CLAIM.
1774	CANNOT DETERMINE MEDICAID ID FROM THE NPI. REFERRING PROVIDER2 TAXONOMY IS REQUIRED FOR THIS DENTAL CLAIM.
	REFERRING PROVIDER2 TAXONOMY ON THIS DENTAL CLAIM IS NOT ON FILE.
1776	REFERRING PROVIDER2 NPI/TAXONOMY COMBINATION NOT FOUND FOR THIS DENTAL CLAIM.
1777	REFERRING PROVIDER2 NPI/TAXONOMY COMBINATION NOT VALID FOR THE DATE OF SERVICEON THIS DENTAL CLAIM.
1778	REFERRING PROVIDER2 MEDICAID PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE ON THIS DENTAL CLAIM.
	THE REFERRING PROVIDER2 ON THIS DENTAL CLAIM IS NOT A VALID ORP MEDICAID PROVIDER TYPE OR IS NOT AN INDIVIDUAL
1780	ATTENDING PROVIDER NPI IS REQUIRED.
1781	ATTENDING PROVIDER NPI IS NOT ON FILE OR NOT VALID FOR THE DATE OF SERVICE.
1782	ATTENDING PROVIDER TAXONOMY IS NOT ON FILE.
1783	CANNOT DETERMINE ATTENDING MEDICAID ID FROM THE NPI. ATTENDING PROVIDER TAXONOMY IS REQUIRED. PLEASE RESUBMIT
1784	ATTENDING PROVIDER NPI/TAXONOMY COMBINATION NOT FOUND.
1785	ATTENDING PROVIDER NPI/TAXONOMY COMBINATION NOT ELIGIBLE FOR THE HEADER FROM DATE OF SERVICE.
1786	ATTENDING PROVIDER MEDICAID ID IS NOT ELIGIBLE FOR THE DATE OF SERVICE.
1787	ATTENDING PROVIDER IS NOT A VALID ORP MEDICAID PROVIDER TYPE.
1788	ATTENDING PROVIDER NPI DOES NOT HAVE A MATCHING ORP PROVIDER FOR THE DATE OF SERVICE.
1789	PRESCRIBING PROVIDER NPI IS NOT ON FILE OR DOES NOT HAVE A MATCHING ELIGIBLE PRESCRIBING PROVIDER FOR THE DATE OF
1800	BILLING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KYHEALTH CHOICES PROVIDER
	RENDERING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KY HEALTH CHOICES PROVIDER
1802	REFERRING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KY HEALTH CHOICES PROVIDER
1803	SERVICE FACILITY NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITHYOUR KY HEALTH CHOICES PROVIDER
1804	DETAIL RENDERING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITHYOUR KY HEALTH CHOICES PROVIDER
1805	DETAIL REFERRING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITHYOUR KY HEALTH CHOICES PROVIDER
1806	BILLING ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE
1807	RENDERING ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE
1808	REFERRING ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE
1809	SERVICE FACILITY ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE
1811	DETAIL RENDERING PROVIDER ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OFSERVICE
1812	DETAIL REFERRING ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE
1814	IF THE BILLING PROVIDER SUBMITS ANY OTHER SECONDARY NUMBER, POST THE EDIT.
1815	RENDERING PROVIDER SUBMITTED OTHER SECONDARY NUMBER ON CLAIM
1816	REFERRING PROVIDER SUBMITTED OTHER SECONDARY NUMBER ON CLAIM
1817	KENTUCKY FACILITY MEDICAID NUMBER SUBMITTED ON CLAIM. A VALID NPI MUST BE SUBMITTED AFTER MAY 22, 2008.
1818	OTHER PROVIDER 2 SUBMITTED OTHER SECONDARY NUMBER ON CLAIM
1819	DETAIL RENDERING PROVIDER SUBMITTED OTHER SECONDARY NUMBER ON CLAIM
1820	DETAIL REFERRING PROVIDER SUBMITTED OTHER SECONDARY NUMBER ON CLAIM
1821	DETAIL OTHER PROVIDER 2 SUBMITTED OTHER SECONDARY NUMBER ON CLAIM.
1822	RENDERING PROVIDER NPI NOT ON KY HEALTH CHOICES FILE
1823	REFERRING PROVIDER NPI NOT ON KY HEALTH CHOICES FILE
1824	SERVICE FACILITY PROVIDER NPI NOT ON KY HEALTH CHOICES FILE
1825	OTHER PROVIDER 2 NPI NOT ON KY HEALTH CHOICES FILE
1826	DETAIL RENDERING PROVIDER NPI NOT ON FILE
1827	DETAIL REFERRING PROVIDER NPI NOT ON FILE
1828	DETAIL OTHER PROVIDER 2 NPI NOT ON FILE
1829	RENDERING PROVIDER NPI NOT ON FILE
1830	REFERRING PROVIDER NPI NOT ON FILE
1831	SERVICE FACILITY PROVIDER NOT ON FILE
1832	OTHER PROVIDER 2 NPI NOT ON FILE
1833	DETAIL RENDERING PROVIDER NPI NOT ON FILE
1834	DETAIL REFERRING PROVIDER NPI NOT ON FILE
1835	DETAIL OTHER PROVIDER 2 PROVIDER NPI NOT ON FILE
1836	BILLING NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM

FOB Code	Description
1837	RENDERING NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1838	REFERRING NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1839	FACILITY NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1840	OTHER PROVIDER 2 NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1841	RENDERING NPI ONLY SUBMITTED ON CLAIM AT DETAIL - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1842	REFERRING NPI ONLY SUBMITTED ON CLAIM AT DETAIL - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1843	OTHER PROVIDER 2 NPI ONLY SUBMITTED ON CLAIM AT DETAIL - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON
1844	KY HEALTH CHOICES BILLING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES OF SERVICE SUBMITTED
1845	KY HEALTH CHOICES RENDERING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIMS DATES OF SERVICE SUBMITTED
1846	KY HEALTH CHOICES REFERRING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIMS DATES OF SERVICE SUBMITTED
1847	KY HEALTH CHOICES SERVICE FACILITY MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATESOF SERVICE SUBMITTED
1848	KY HEALTH CHOICES OTHER PROVIDER 2 MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATESOF SERVICE SUBMITTED
1849	KY HEALTH CHOICES DETAIL RENDERING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATESOF SERVICE SUBMITTED
1850	KY HEALTH CHOICES DETAIL REFERRING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATESOF SERVICE SUBMITTED
1851	KY HEALTH CHOICES DETAIL OTHER PROVIDER 2 MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES OF SERVICE SUBMITTED
1852	SUBMITTED BILLING TAXONOMY CODE AT HEADER IS NOT A VALID CODE - CHECK FOR VALIDTAXONOMY CODES AT WWW.WPC-
1853	SUBMITTED RENDERING TAXONOMY CODE AT HEADER IS NOT A VALID CODE - CHECK FOR VALID TAXONOMY CODE AT WWW.WPC-
1854	WARNING - SUBMITTED REFERRING TAXONOMY CODE AT HEADER IS NOT VALID CODE - CHECKFOR VALID TAXONOMY CODES AT
1856	SUBMITTED DETAIL RENDERING TAXONOMY CODE IS NOT A VALID CODE - CHECK FOR VALID TAXONOMY CODE AT WWW.WPC-
1857	BILLING TAXONOMY CODE FOR PROVIDER NOT VALID FOR DATE OF SERVICE
1858	RENDERING TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE
1859	REFERRING TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE
1861	DETAIL RENDERING TAXONOMY CODE FOR PROVIDER NOT VALID FOR DATE OF SERVICE
1862	BILLING PROVIDER TAXONOMY CODE NOT VALID FOR PROVIDER FOR DATE OF SERVICE.
1863	HEADER RENDERING PROVIDER TAXONOMY CODE NOT VALID FOR PROVIDER FOR DATE OF SERVICE.
1864	
1866	REFERRING PROVIDER TAXONOMY CODE MIS/MATCH FOR CLAIM DATE OF SERVICE DETAIL RENDERING PROVIDER TAXONOMY CODE NOT VALID FOR PROVIDER FOR DATE OF SERVICE.
1870	BILLING PROVIDER SUBMITTED NPI AND LEGACY NUMBER. LEGACY NUMBER NOT PROCESSED
	REFERRING PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSED
1871 1872	
1873	RENDERING PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSED SERVICE FACILITY PROV SUBMITTED NPI AND LEGACY NUM- LEGACY NUM NOT PROCESSED
1874 1875	OTHER PROVIDER 2 PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSED
	RENDERING PROVIDER SUBMITTED NPI AND LEGACY NUMBER. LEGACY NUMBER NOT PROCESSED
1876	REFERRING PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSED
1877	OTHER PROVIDER 2 PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSED
1878	PRESCRIBER'S NPI IS INVALID
1879	PRESCRIBER'S NPI IS MISSING
1880	PRESCRIBER'S NPI IS NOT ON FILE
1881	BILLING PROVIDER TAXONOMY IS MISSING.
1882	RENDERING PROVIDER TAXONOMY IS MISSING.
1900	NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KY HEALTHCHOICES PROVIDER IDENTIFICATION
1901	NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KY HEALTHCHOICES PROVIDER IDENTIFICATION
1902	KY HEALTH CHOICES MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES OF SERVICE SUBMITTED
1903	KY HEALTH CHOICES MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES OF SERVICE SUBMITTED
1904	WARNING - NPI AND KY HEALTH CHOICES MEDICAID NUMBER SUBMITTED ON CLAIM - NPI ISNOT ELIGIBLE FOR THE CLAIM
1905	WARNING - NPI AND KY HEALTH CHOICES MEDICAID NUMBER SUBMITTED ON CLAIM - NPI ISNOT ELIGIBLE FOR THE CLAIM
1906	WARNING - NPI NOT REGISTERED WITH KY HEALTH CHOICES - NPI SUBMITTED ON CLAIM ATHEADER NOT ON FILE - PLEASE VERIFY
1907	WARNING - NPI NOT REGISTERED WITH KY HEALTH CHOICES - NPI SUBMITTED ON CLAIM ATDETAIL NOT ON FILE - PLEASE VERIFY
1908	BILLING NPI ONLY SUBMITTED ON CLAIM. NPI IS NOT ON FILE
1909	TAXONOMY IS NOT VALID FOR FACILITY PROVIDER
1910	NPI ONLY SUBMITTED ON CLAIM AT HEADER ? NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1911	NPI ONLY SUBMITTED ON CLAIM AT DETAIL ? NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1912	WARNING - SUBMITTED TAXONOMY CODE AT HEADER IS NOT A VALID CODE - CHECK FOR VALID TAXONOMY CODES AT
	WWW.WPC-EDI.COM

FOR Code	Description
1913	WARNING - SUBMITTED TAXONOMY CODE AT DETAIL IS NOT A VALID CODE - CHECK FOR VALID TAXONOMY CODES AT
	WWW.WPC-EDI.COM
1914	PROVIDER NPI NOT ON KY HEALTH CHOICES FILE
1915	PROVIDER NPI NOT ON FILE
1916	PROVIDER NPI NOT ON FILE
1917	PROVIDER NPI NOT ON FILE - DETAIL
1918	WARNING - BILLING PROVIDER 5 DIGIT ZIP CODE DOES NOT MATCH WHAT IS REGISTERED WITH KY HEALTH CHOICES - PLEASE VERIFY
1919	WARNING - BILLING PROVIDER 5 + 4 DIGIT ZIP CODE DOES NOT MATCH WHAT IS REGISTERED WITH KY HEALTH CHOICES - PLEASE
1920	WARNING - KENTUCKY MEDICAID NUMBER SUBMITTED ON CLAIM. A VALID NPI ONLY MUST BE SUBMITTED AFTER MAY 22, 2008
1921	WARNING - KENTUCKY MEDICAID NUMBER SUBMITTED ON CLAIM AT DETAIL - NPI ONLY MUSTBE SUBMITTED AFTER MAY 22, 2008
1922	MULTIPLE KY MEDICAID MATCHES FOUND FOR NPI SUBMITTED - SERVICE FACILITY 5 DIGITZIP CODE SUBMITTED ON CLAIM DOES
1923	MULTIPLE KY MEDICAID MATCHES FOUND FOR NPI SUBMITTED - SERVICE FACILITY 5 + 4 DIGIT ZIP CODE SUBMITTED ON CLAIM DOES
1924	TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE
1925	TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE
1926	
1927	PROVIDER TAXONOMY CODE MIS/MATCH FOR CLAIM DATE OF SERVICE PROVIDER TAXONOMY CODE MIS/MATCH FOR CLAIM DATE OF SERVICE
1936	INVALID BILLING PROVIDER OVERRIDE SPECIFIED
1936	INVALID PERFORMING PROVIDER OVERRIDE SPECIFIED
1938	INVALID REFERRING PROVIDER OVERRIDE SPECIFIED
1939	INVALID FACILITY PROVIDER OVERRIDE SPECIFIED
1940	INVALID RENDERING PROVIDER OVERRIDE SPECIFIED
1941	INVALID OTHER PROVIDER 2 OVERRIDE SPECIFIED
1942	INVALID DTL OTHER PROVIDER 2 OVERRIDE SPECIFIED
1943	INVALID DTL PERFORMING PROVIDER OVERRIDE SPECIFIED
1944	INVALID DTL REFERRING PROVIDER OVERRIDE SPECIFIED
1945	MULTIPLE SERVICE LOCATIONS FOR BILLING PROVIDER
1946	MULTIPLE SERVICE LOCATIONS FOR PERFORMING PROVIDER
1947	MULTIPLE SERVICE LOCATIONS FOR REFERRING PROVIDER
1948	MULTIPLE SERVICE LOCATIONS FOR FACILITY PROVIDER
1949	MULTIPLE SERVICE LOCATIONS FOR RENDERING PROVIDER
1950	PROCEDURE INCLUDED IN BUNDLED RATE
1951	HCPC IS REQUIRED
1952	MULTIPLE SERVICE LOCS FOR DTL PERFORMING PROVIDER
1953	MULTIPLE SERVICE LOCS FOR DTL REFERRING PROVIDER
1955	CLAIM/SERVICE DENIED. THE BILLING PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE
1956	CLAIM/SERVICE DENIED. THE REFERRING PROVIDER NPI SUBMITTED ON THE CLAIM CANNOTBE USED TO UNIQUELY IDENTIFY THE
1957	CLAIM/SERVICE DENIED. THE FACILITY PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE
1958	CLAIM/SERVICE DENIED. THE OTHER PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BEUSED TO UNIQUELY IDENTIFY THE OTHER
1959	CLAIM/SERVICE DENIED. THE PERFORMING PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE
1960	CLAIM/SERVICE DENIED. THE DETAIL REFERRING PROVIDER NPI SUBMITTED ON THE CLAIMCANNOT BE USED TO UNIQUELY IDENTIFY
1961	CLAIM/SERVICE DENIED. THE DETAIL OTHER PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE
1962	CLAIM/SERVICE DENIED. THE DETAIL PERFORMING PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY
1963	CLAIM/SERVICE DENIED. THE KENPAC PROVIDER NPI SUBMITTED ON THE CLAIM DOES NOT MATCH THE PRIMARY CARE PHYSICIAN
1964	THE LOCK IN PROVIDER NPI SUBMITTED ON THE CLAIM DOES NOT MATCH THE PRIMARY CAREPHYSICIAN FOR THE MEMBER ON THE
1965	CLAIM DENIED. PLEASE RESUBMIT CLAIM WITH THE NPI THAT CORRESPONDS TO YOUR KY MEDICAID PROV NUMBER. IF YOU HAVE
1966	THE PROVIDER NPI AND TAXONOMY SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELYIDENTIFY THE PROVIDER
1967	THE PROVIDER NPI AND SERVICE FACILITY 5 DIGIT ZIP CODE SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE
1968	THE PROVIDER NPI AND SERVICE FACILITY 5 + 4 DIGIT ZIP CODE SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY
1969	THE PROVIDER NPI AND BILLING PROVIDER 5 DIGIT ZIP CODE SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY
1970	THE PROVIDER NPI AND BILLING PROVIDER 5 + 4 DIGIT ZIP CODE SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY
1971	THE KY MEDICAID NUMBER SUBMITTED ON THE CLAIM DOES NOT MATCH THE CROSS-WALKED KY MEDICAID NUMBER FROM THE NPI
1972	THE KY MEDICAID NUMBER SUBMITTED ON THE CLAIM DOES NOT MATCH THE CROSS-WALKED KY MEDICAID NUMBER FROM THE NPI
1995	MMIS FACILITY PROVIDER ID NOT ENROLLED
1996	THE RENDERING PROVIDER IS NOT ENROLLED IN THE MEDICAID PROGRAM.
1997	THIS CLAIM WAS BILLED WITH A RENDERING PROVIDER NUMBER FROM THE PREVIOUS MEDICAID SYSTEM. PLEASE BILL FUTURE

FOR Code	Description
1999	BILLING PROVIDER ID SUMITTED UNDER OLD FORMAT
2000	ERROR DISPOSITION SETUP IS INVALID
2001	MEMBER ID NUMBER NOT ON FILE.
2002	MEMBER NOT ELIGIBLE FOR HEADER DATE OF SERVICE.
2002	MEMBER INELIGIBLE FOR HEADER DATE OF SERVICE.
2003	PROCEDURE INCLUDED IN COMBINED PROCEDURE
2005	PRESCRIPTION LIMIT EXCEEDED FOR THIS MONTH RX-EXCEEDS DAYS SUPPLY LIMIT/REQUIRES PA
2007	PA NOT AUTHORIZED FOR DRUG THERCLASS 46 & 47
2008	EXCEEDS EMERGENCY ROOM VISITS FOR THIS DATE
2009	MEMBER INELIGIBLE ON DATE OF SERVICE.
2010	MULTIPLE ACTIVE PREVIOUS ID'S FOUND FOR MEMBER.
2011	MATERNITY CLINIC/PHY CONFLICT FOR PRENATAL SERVICE
2012	MAXIMUM CRITICAL CARE VISITS EXCEEDED
2013	EXCEEDS 9 MO LIMIT FOR THIS LEVEL PRENATAL CARE
2014	EXCEEDS MONTHLY CLINIC VISIT LIMITS
2015	SCHOOL BASED YEARLY LIMIT EXCEEDED
2016	LIMIT OF HH VISITS HAS BEEN EXCEEDED FOR 1 YEAR
2017	LIMIT FOR CHMC SERVICE HAS BEEN EXHAUSTED
2018	DIABETIC SUPPLIES LIMITS EXCEEDED
2019	12 MONTH LIMIT FOR THIS DENTAL SERVICE IS EXCEEDED
2020	YEARLY LIMIT FOR EYE GLASSES EXCEEDED
2021	12 MONTH LIMIT FOR THIS DENTAL SERVICE IS EXCEEDED
2022	A CONFLICTING SERVICE HAS BEEN PAID FOR THIS DATE
2023	DEALER LIMITS EXCEEDED
2024	OTHER FED QUAL HEALTH CENTER SERV PAID THIS DATE
2025	EXCEEDS EARLY INTERVENTION SERVICES LIMITS
2026	EXCEEDS EPSDT CLINIC LIMITS
2027	EXCEEDS OB ULTRASOUND LIMIT FOR 9 MONTHS
2028	EXCEEDS NUTRITIONAL SERVICE FOR YEAR
2029	EXCEEDS HOME COM BASED WAIVERED SERVICE LIMITS
2030	SAME SERV WITH 91/92 HCPC HAS BEEN PAID THIS DATE
2031	EXCEPTION CODE 031
2032	MAXIMUM RENTAL PAYMENT
2033	HIGHER CEREBRAL FUNCTION PREVIOUSLY PAID IN 12 MTS
2034	EXCEEDS YEARLY EARLY INTERVENTION CASE MAN LIMITS
2035	THE 2 PHY VISIT PER MONTH LIMIT HAS BEEN EXCEEDED
2036	ADD'L HOURS OF TESTING REQUIRE PRIOR AUTHORIZATION
2037	MAXIMUM PAYMENT MADE
2038	EXCEEDS OXYGEN LIMITS-ONE PER MONTH
2039	TARGETED ULTRASOUND/AMNIOCENTISIS REVIEW
2040	THE MAMMOGRAM LIMIT HAS BEEN EXCEEDED
2041	EXCEPTION CODE 041
2042	EXCEEDS ONCE PER MONTH LIMIT
2043	ONE NEWBORN EXAM HAS BEEN PAID FOR THIS CHILD
2044	PREVIOUSLY PAID-VISIT OR W3011-THIS DATE OF SERV.
2045	EXCEPTION CODE 045
2046	EXCEPTION CODE 046
2047	EXCEED PART A SKILLED NURSING FACILITY COINS LIMIT
2048	CONFLICTING DENTAL SERVICE SAME DAY
2049	EXCEEDS PSYCHOLOGICAL LIMIT PER MONTH
2050	EXCEPTION CODE 050
2051	EXCEEDS 2 VISIT LIMIT
2052	NO LTC STAFFING SUBMITTED FOR SERVICE MONTH
2053	LTC EMC CLAIM INVALID WHEN STAFFING IS SENT PAPER

P. C. INCLUSINE FOR CATEGORY OF SERVICE	FOR Code	Description
2055 2 RURAL HEALTH WIST'S PER MONTH HAS BEEN EXCEDED 2056 1 RIGGER POINT INJECTION LIMIT HAS BEEN EXCEDED 2057 0 UTTATIENT MENTAL HEALTH HURITS EXCEDED 2058 WEARTY ASSISTATIVE TECHNOLOGY LIMIT EXCEEDED 2059 WEARTY ASSISTATIVE TECHNOLOGY LIMIT EXCEEDED 2059 WEARTY ASSISTATIVE TECHNOLOGY LIMIT EXCEEDED 2060 PRESC PRACT L'ECRISE NUMBER NOT IN VALID FORMAT 2060 PRESC PRACT L'ECRISE NUMBER NOT IN VALID FORMAT 2060 PRESC PROTIC CODE 606 2061 EXCEPTION CODE 606 2062 EXCEPTION CODE 608 2065 EXCEPTION CODE 606 2066 EXCEPTION CODE 606 2067 EXCEPTION CODE 606 2068 EXCEPTION CODE 606 2069 EXCEPTION CODE 608 2070 2 NURSING HOME VISTS PREVIOUSLY PAID THIS MONTH 2071 THIS SERV HAS BEEN PREVIOUSLY PAID THIS MONTH 2072 PREVIOUSLY PAID VISIAL EARLY IN LAW MONTHS 2073 RURSING HOME VISTS PREVIOUSLY PAID THIS MEMBER 2074 PREVIOUSLY PAID SEEN PREVIOUSLY PAID THIS MEMBER 2075 PREVIOUSLY PAID SEEN PREVI		
TRIGGER POINT INJECTION LIMIT HAS BEEN EXCEEDED	-	
2057 OUTPATIENT MENTAL HEALTH LIMITS EXCEDED 2058 VERY ASSISTATIVE TECHNOLOGY LIMIT EXCEEDED 2059 EXCEPTION CODE 059 2050 PRESC PRACT LICENSE NUMBER NOT IN VALID FORMAT 2050 PRESC PRACT LICENSE NUMBER NOT IN VALID FORMAT 2050 PRESC PRACT LICENSE NUMBER NOT IN VALID FORMAT 2051 EXCEPTION CODE 061 2052 EXCEPTION CODE 062 2053 EXCEPTION CODE 062 2053 EXCEPTION CODE 063 2054 EXCEPTION CODE 063 2056 EXCEPTION CODE 064 2056 EXCEPTION CODE 065 2056 EXCEPTION CODE 065 2057 EXCEPTION CODE 065 2058 EXCEPTION CODE 065 2059 EXCEPTION CODE 065 2050 EXCEPTION CODE 069 2070 INTERPRESENT OF CODE 065 2050 EXCEPTION CODE 069 2070 INTERPRESENT CODE 065 2050 EXCEPTION CODE 069 2070 INTERPRESENT CODE 065 2050 EXCEPTION CODE 069 2070 PREVIOUSLY PAID VISUAL EXAMINATE VISUA		
VEARLY ASSISTATIVE TECHNOLOGY LIMIT EXCEEDED 2059 EXCEPTION CODE 059 206 PRESC PRACT LICENSE NUMBER NOT IN VALID FORMAT 2060 EXCEPTION CODE 060 2061 EXCEPTION CODE 060 2062 EXCEPTION CODE 061 2062 EXCEPTION CODE 063 2063 EXCEPTION CODE 063 2064 EXCEPTION CODE 064 2065 EXCEPTION CODE 064 2066 EXCEPTION CODE 065 2066 EXCEPTION CODE 065 2066 EXCEPTION CODE 066 2067 EXCEPTION CODE 067 2070 2 NURSING HOME VISITS PREVIOUSLY PAID THIS MONTH 2071 THIS SERV HAS BEEN PREVIOUSLY PAID THIS MONTH 2071 THIS SERV HAS BEEN PREVIOUSLY PAID TORTHIS MONTH 2072 PREVIOUSLY PAID SEAL EXAMIN 12 MONTHS 2073 EXCEPTION CODE 073 2074 REVIOUSLY PAID SEAR EXAMIN 12 MONTHS 2075 EXCEPTION CODE 073 2076 EXCEPTION CODE 073 2077 EXCEPTION CODE 073 2078 MEMBER HAS OVERLAPPING PAITENT LIABILITY SEGMENTS. PLEASE CONTACT EDS PROVIDERRELATIONS. 2076 EXCEPTION CODE 077 2078 MEMBER HAS OVERLAPPING PAITENT LIABILITY SEGMENTS. PLEASE CONTACT EDS PROVIDERRELATIONS. 2079 EXCEPTION CODE 077 2080 PREVIOUSLY PAID AUDITORY EXAMIN 12 MONTHS 2081 EXCEPTION CODE 077 2080 PREVIOUSLY PAID AUDITORY EXAMIN 12 MONTHS 2081 CHILDRENS DAYS EXCEEDED 2082 CHILDRENS DAYS EXCEEDED 2083 CHILDRENS DAYS EXCEEDED 2084 CHILDRENS DAYS EXCEEDED 2085 CHILDRENS DAYS EXCEEDED 2086 CHILDREN DAYS EXCEEDED 2087 EXCEPTION CODE 088 2088 EXCEPTION CODE 088 2089 EXCEPTION CODE 089 2091 MEMBER HAS MULTIPLE INSTITUTIONAL STATUS CODE, PLEASE CONTACT EDS. 2010 MEMBER HAS MULTIPLE INSTITUTIONAL STATUS CODE, PLEASE CONTACT EDS. 2011 MEMBER HAS MULTIPLE INSTITUTIONAL STATUS CODE, PLEASE CONTACT EDS. 2012 ALBERT NOR OF CODE 088 2013 CHILDREN DAYS EXCELEDED 2014 MEMBER HAS MULTIPLE INSTITUTIONAL STATUS CODE, PLEASE CONTACT EDS. 2015 AUDITORY EXAMINED DAYS EXCELEDED 2016 MEMBER HAS MULTIPLE INSTITUTIONAL STATUS CODE, PLEASE CONTACT EDS. 2017 AUDITORY EXAMINED CODE 089 2018 HAS MULT		
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REVIEW INVALID CARRIER DENIED BATCH DDSD HAS DENIAL/SUSPEND EDIT MANUALLY SUSPEND FOR HCA ADP WAIVER HAS DENY/SUSPEND EDIT PROCEDURE NOT COVERED WITH THIS PLACE OF SERVICE INVALID PROVIDER SPECIALTY FOR PROCEDURE INVALID DIAGNOSIS FOR PROCEDURE MEMBER NAME IS MISSING PCS CLAIM - MEMBER NOT PCS ELIGIBLE MISSING TOTAL CHARGE FOR NURSING HOME CLAIMS UTTPT HSP PRIOR TO 12/01/99-SUSPEND FOR REVIEW VISIT WITHIN NORMAL SURGERY FOLLOW-UP PERIOD EXCEPTION CODE 116	2091	MEMBER HAS MULTIPLE INSTITUTIONAL STATUS CODE. PLEASE CONTACT EDS.
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2105 INVALID DIAGNOSIS FOR PROCEDURE 2106 MEMBER NAME IS MISSING 2110 PCS CLAIM - MEMBER NOT PCS ELIGIBLE 2112 MISSING TOTAL CHARGE FOR NURSING HOME CLAIMS 2114 OUTPT HSP PRIOR TO 12/01/99-SUSPEND FOR REVIEW 2115 VISIT WITHIN NORMAL SURGERY FOLLOW-UP PERIOD 2116 EXCEPTION CODE 116	2103	PROCEDURE NOT COVERED WITH THIS PLACE OF SERVICE
2106 MEMBER NAME IS MISSING 2110 PCS CLAIM - MEMBER NOT PCS ELIGIBLE 2112 MISSING TOTAL CHARGE FOR NURSING HOME CLAIMS 2114 OUTPT HSP PRIOR TO 12/01/99-SUSPEND FOR REVIEW 2115 VISIT WITHIN NORMAL SURGERY FOLLOW-UP PERIOD 2116 EXCEPTION CODE 116	2104	INVALID PROVIDER SPECIALTY FOR PROCEDURE
2110 PCS CLAIM - MEMBER NOT PCS ELIGIBLE 2112 MISSING TOTAL CHARGE FOR NURSING HOME CLAIMS 2114 OUTPT HSP PRIOR TO 12/01/99-SUSPEND FOR REVIEW 2115 VISIT WITHIN NORMAL SURGERY FOLLOW-UP PERIOD 2116 EXCEPTION CODE 116	2105	INVALID DIAGNOSIS FOR PROCEDURE
2112 MISSING TOTAL CHARGE FOR NURSING HOME CLAIMS 2114 OUTPT HSP PRIOR TO 12/01/99-SUSPEND FOR REVIEW 2115 VISIT WITHIN NORMAL SURGERY FOLLOW-UP PERIOD 2116 EXCEPTION CODE 116	2106	MEMBER NAME IS MISSING
2114 OUTPT HSP PRIOR TO 12/01/99-SUSPEND FOR REVIEW 2115 VISIT WITHIN NORMAL SURGERY FOLLOW-UP PERIOD 2116 EXCEPTION CODE 116	2110	PCS CLAIM - MEMBER NOT PCS ELIGIBLE
2115 VISIT WITHIN NORMAL SURGERY FOLLOW-UP PERIOD 2116 EXCEPTION CODE 116	2112	MISSING TOTAL CHARGE FOR NURSING HOME CLAIMS
2116 EXCEPTION CODE 116	2114	OUTPT HSP PRIOR TO 12/01/99-SUSPEND FOR REVIEW
	2115	VISIT WITHIN NORMAL SURGERY FOLLOW-UP PERIOD
2117 2 YEAR RESUBMISSION DEADLINE EXCEEDED	2116	EXCEPTION CODE 116
	2117	2 YEAR RESUBMISSION DEADLINE EXCEEDED

EOR Codo	Description
2118	DISCHARGE DATE IS LESS THAN ADMIT DATE
-	
2119	DISCHARGE DATE IS LESS THAN LAST DATE OF SERVICE
2120	VISIT PAID IN NORMAL SURGERY FOLLOW-UP PERIOD
2121	CLAIM WAS FILED WITHOUT SERVICING PROVIDER
2122	INVALID/MISSING PROVIDER CHECK-DIGIT NUMBER
2123	INVALID/MISSING PAY-TO PROVIDER CHECK-DIGIT NUMBER
2124	MISSING FIRST DATE OF SERVICE ON CLAIM
2125	ONE YEAR TIMELY FILING DEADLINE EXCEEDED-FED REG
2126	FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV
2127	DATE RECEIVED FOR PROCESSING-PRIOR TO DATE OF SERV
2128	DATE OF ACCIDENT IS GREATER THAN LAST DATE OF SERV
2129	MISSING MEMBER ID NUMBER ON CLAIM
2130	EXCEPTION CODE 130
2132	MISSING TOTAL CLAIM CHARGE
2133	INVALID TOTAL CLAIM CHARGE
2134	INVALID NET CLAIM CHARGE
2136	MISSING/INVALID REVENUE CODE
2138	MISSING/INVALID TYPE OF BILL
2140	HCPC CODE IS INVALID FOR REVENUE CODE
2141	TOTAL DAYS LESS THAN COVERED DAYS
2142	1 YR TIMELY FILE HAS BEEN OVERRIDDEN-TF ATTACHED
2143	REFILLS EXHAUSTED
2144	INVALID REFILL INDICATOR VALUE
2146	HCPC/REVENUE CODE MISSING
2147	DIAGNOSIS NOT COVERED FOR THIS CLAIM TYPE FOR MEMBER'S BENEFIT PLAN
2148	PROCEDURE NOT PAYABLE THIS MEMBER
2149	PROC REQUIRES REVIEW CATEGORICALLY NEEDY MEMBER
2150	UNITS OF SERVICE ARE LESS THAN PROC ALLOWED UNITS
2151	MISSING PRESCRIBING PROVIDER NUMBER
2152	MISSING DRUG CODE
	INVALID DRUG CODE
2153	
2154	MISSING PRESCRIPTION NUMBER
2155	MISSING DRUG QUANTITY
2156	MISSING DAYS SUPPLY
2160	MISSING DIAGNOSIS INDICATOR
2163	MISSING DIAGNOSIS CODE
2166	MEMBER ELIGIBILITY PENDING DHS APPROVAL
2167	INVALID PATIENT STATUS
2168	INVALID SOURCE OF ADMISSION
2170	INVALID PLACE OF SERVICE
2172	CLAIM REQUIRES HCPC OR CPT-4 CODE
2173	ADMIT DATE GREATER THAN FIRST DATE OF SERVICE
2174	UNITS CANNOT BE LESS THAN DAYS
2175	SURGICAL PROCEDURE MISSING
2176	MEMBER NOT ON FILE PAY FROM STATE FUNDS
2178	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2179	MISSING TOOTH SURFACE
2180	INVALID TOOTH NUMBER
2181	INVALID TOOTH SURFACE
2182	MISSING TOOTH NUMBER
2183	MISSING UNITS OF SERVICE
2184	MISSING CHARGE
2185	LTC MISSING ADMISSION DATE
2186	INVALID ADMISSION HOUR
2187	PROCEDURE NOT PAYABLE THIS MEMBER
210/	I NOCEDONE NOT LATABLE THIS WILLIAMEN

EOB Code	Description
2189	PROCEDURE REQUIRES MEDICAL REVIEW
-	
2190	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2191	ITEM DAYS NOT EQUAL TO COVERED DAYS ON CLAIM
2192	TOTAL DAYS ON CLAIM CONFLICT WITH DATES SHOWN
2193	MISSING COVERED DAYS
2194	AGE IS NOT COVERED INPATIENT PSYCHIATRIC SERVICES
2196	MISSING ADMISSION DATE
2197	INVALID INPATIENT REVENUE CODE
2198	MISSING ATTENDING SURGEON PRESCRIBER NUMBER
2199	DATE OF SURGERY IS MISSING
2200	INVALID TYPE OF ADMISSION
2201	PROCEDURE CODE IS NOT IN THE SCOPE OF PROGRAM
2202	SUB TYPE REQUIRED FOR THIS DIAGNOSIS CODE
2203	CLAIMANT SIGNATURE MISSING
2204	PROVIDER SIGNATURE IS MISSING
2205	PATIENT NOT CERTIFIED
2206	PRESCRIBING PROVIDER NUMBER NOT IN VALID FORMAT
2207	INVALID LEVEL OF CARE
2208	INVALID PICKUP LOCATION
2209	INVALID DESTINATION
2210	FACILITY PROVIDER SERVICE LOCATION IS MISSING
2213	PREGNANCY INDICATOR INVALID
2214	DATE PRESCRIBED IS INVALID
2214	DATE I RESCRIBED IS INVALID
2215	DATE DISPENSED IS MISSING
2216	DATE DISPENSED IS INVALID
2222	MISSING OCCURRENCE DATE
2223	SERVICE DATES ARE NOT IN SAME MONTH
2224	INVALID OCCURRENCE DATE
2226	INVALID CONDITION CODE
2227	EXCEPTION CODE 227
2228	MISSING MEDICARE PAID DATE
2230	NO CROSSOVER COINSURANCE OR DEDUCTIBLE DUE
2231	ESTIMATED DAYS SUPPLY INVALID
2233	INSURANCE DENIAL REQUIRED
2234	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2235	SURGERY DATE CANNOT BE PRIOR TO ADMIT DATE
2236	SURGERY DATE CANNOT BE OUTSIDE DATE OF SERVICE
2237	FACILITY PROVIDER NOT IN VALID FORMAT
2238	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN
2239	INVALID OCCURRENCE CODE
2240	THE DETAIL LINE "TO" DATE OF SERVICE IS MISSING.
2242	MISSING OCCURRENCE CODE
2244	INVALID PAY-TO PROVIDER NUMBER
2247	MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED
2249	CLAIM HAS NO DETAILS
2250	MEMBER IS NOT ON ELIGIBILITY FILE
2252	MEMBER IS NOT ELIGIBLE ALL DATES OF SERVICES
2253	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN
2254	MEMBER NOT IN MANAGED CARE
2258	MEMBER IS NOT ON ELIGIBILITY FILE
2259	DATE BILLED IS INVALID
2260	SLIMB ONLY/NO MEDICAL ELIGIBILITY
2262	PROCEDURES NOT PAYABLE TB
2263	PROCEDURE REQUIRES REVIEW FOR TB MEMBER

2266 REFERING PHYSICAN NUMBER IS MISSING 2270 INPATIENT TEN NOT COVERED 2271 MEMBER IS NOT ELIGIBLE ON SERVICE DATE 2272 ITEMIZED SERVICE DATE NOT IN ELIGIBLITY SPAN 2273 SUSPENDED FOR MEMBER REVIEW 2274 CLAIN INDICATES MEMBER REVIEW 2275 NEW SOUTH NUMBER IS NOT ELIGIBLE ON SERVICE DATE 2276 CLAIN INDICATES MEMBER REVIEW 2277 BILLING PROVIDER IS NOT LISTED AS MEMBER'S LTC PROVIDER. 2278 DISCHARGE OF UNEQ TO LISTED AS MEMBER'S LTC PROVIDER. 2278 DISCHARGE OF UNEQ TO LISTED AS MEMBER'S LTC PROVIDER. 2278 DISCHARGE OF UNEQ TO LISTED AS MEMBER'S LTC PROVIDER. 2278 DISCHARGE OF UNEQ TO LISTED AS MEMBER'S LTC PROVIDER. 2281 ABROTION NOT COVERED 2282 PHYSICAN AUDITOR REVIEW MODIFIER 24 2283 MEMBER NOT LIGIBLE FOR DATES OF SERVICE 2286 PROCEDURE IN OT PAYABLE VIR 2287 PROCEDURE REQUIES PRIOR AUTHORIZATION 2290 PROCEDURE REQUIES PROVIDER SENDER MEMBER'S LTC PROVIDER 2291 PROCEDURE REQUIES PROVIDER MEMBER MEDICAL REVIEW 2292 PROCEDURE REQUIES PROVIDER MEDICAL REVIEW 2293 PROCEDURE REQUIES PROVIDER MEDICAL REVIEW 2294 PROCEDURE REQUIES PROVIDER MEDICAL REVIEW 2295 PROVIDER MEDICAL REVIEW HORW 2296 PROCEDURE REQUIES PROVIDER SUSTINATION 2297 PROVIDER MEDICAL REVIEW HORW 2298 PROVIDER REQUIES PROVIDER NEW AUTHORIZATION 2299 PROVIDER MEDICAL REVIEW HORW 2299 PROVIDER REQUIES PROVIDER NOT ON FILE 2290 PROVIDER MEDICAL REVIEW HORW 2290 PROVIDER REQUIES PROVIDER NOT ON FILE 2290 PROVIDER MEDICAL REVIEW HORW 2291 PROVIDER NOT ON FILE 2292 PROVIDER MEDICAL REVIEW HORW 2293 PROVIDER NOT ON FILE 2294 PROVIDER NOT ON FILE 2295 PROVIDER NOT ON FILE 2296 PROVIDER NOT ON FILE 2296 PROVIDER NOT ON FILE 2297 PROVIDER NOT ON FILE 2298 PROVIDER NOT ON FILE 2299 PROVIDER NOT ON FILE 2290 PROVIDER NOT ON FILE 2291 PROVIDER NOT ON FILE 2291 PROVIDER NOT ON FILE 2292 PROVIDER SUSPENDED ON FERNING NOT ON FILE 2293 PROVIDER SUSPENDED ON FERNING NOT ON FILE 2294 PROVIDER SUSPENDED ON FERNING NOT ON FILE 2295 PROVIDER SUSPENDED ON FERNING NOT ON FILE 2296 PROVIDER NOT ON	FOR Code	Description
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2335 LTC MEMBER - NONCOMP DRUG	2332	INVALID PROVIDER TYPE FOR THIS PROCEDURE
	2335	LTC MEMBER - NONCOMP DRUG
2336 REFILLS ARE NOT ALLOWED FOR NARCOTIC DRUGS	2336	REFILLS ARE NOT ALLOWED FOR NARCOTIC DRUGS
2337 THIS DRUG REQUIRES PRIOR AUTHORIZATION	2337	THIS DRUG REQUIRES PRIOR AUTHORIZATION

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2425 THIS PROCEDURE MUST BE BILLED SEPARATELY EACH DATE	2420	THIS DRUG NOT PAYABLE FOR MEMBER AGE
	2421	THIS DRUG NOT PAYABLE FOR MEMBER SEX
2430 LTC INVALID MEMBER ID NUMBER	2425	THIS PROCEDURE MUST BE BILLED SEPARATELY EACH DATE
	2430	LTC INVALID MEMBER ID NUMBER

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INVALID DIAGNOSIS TREATMENT INDICATOR	2451	LTC INV PROVIDER NUMBER
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	2497	NO CLIA - DOS PRIOR TO CLIA - EFFECTIVE DATE

FOR Code	Description
	NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE
	TPL PAY CHASE IMMUNO SUPPRESS DRUG
	TPL - PAY AND REPORT
	SUSPEND FOR TPL REVIEW
	FILE CLAIM WITH MEDICARE
	THIS PATIENT HAS OTHER INSURANCE
	CLAIM DOCUMENTATION INDICATES OTHER INSURANCE PAYMENT WAS RECEIVED BY MEMBER OR IS NOT SUFFICIENT.
	EPSDT-MAY HAVE TPL
	TPL PAY AND CHASE PHARMACY
	TPL PAY AND CHASE PRE-NATAL
	THIS PATIENT HAS TWO COVERAGE TYPES
	PROVIDER TYPE - CLAIM INPUT CONFLICT
	DRUG REQUIRES PRIOR AUTHORIZATION
	DRUG QUANTITY PER DAY LIMIT HAS BEEN EXCEEDED
	MEMBER IS NOT ELIGIBLE FOR THESE SERVICES
	OVERNITE LABOR ROOM REQUIRES OCC CODE 51 AND DATE
	PCS PRIOR AUTHORIZATION NOT ON FILE
	PCS-NO UNITS AUTHORIZED-THESE DATES OF SERVICES
	PCS PRIOR AUTHORIZATION UNITS USED
	TIER 2 NSAID NO RECORD OF TIER 1'S ON FILE
	DISEASE STATE MANAGEMENT
	PDUR DRUG-ALLERGY INTERACTION
2534	PRODUR DRUG-AGE INTERACTION
2535	PDUR INGREDIENT DUPLICATION
2536	PDUR THERAPEUTIC DUPLICATION
2537	PDUR DRUG-TO-DRUG INTERACTION
2538	HMO CO-PAY/MEMBER HAS TPL
2539	PDUR EARLY REFILL ON PRESCRIPTION
2540	PDUR MINIMUM DURATION OF THERAPY
2541	PDUR DOSING PRECAUTION-HIGH DOSE
2542	PDUR DOSING PRECAUTION-LOW DOSE
2543	PDUR BREAST FEEDING/PREGNANCY PRECAUTION
2544	PDUR MAXIMUM DURATION OF THERAPY
2545	PDUR LATE REFILL ON PRESCRIPTION
2546	DRUG DISEASE MARKER
2547	HMO CO-PAY/MEMBER HAS MEDICARE
2548	PAY TO PROV FOR PROVIDER TYPE 63 MUST BE GROUP
2549	ADJUSTMENT SUSPEND FOR MANUAL REVIEW
2550	SERVICE NOT REFERRED BY PRIMARY CARE CASE MANAGER
2552	PROVIDER NOT ELIGIBLE TO PROVIDE SERVICE/MEDICAID
2555	CLAIM PAST 24 MONTH FILING - DTL
2556	MEMBER IS NOT WAIVER ELIGIBLE
2557	CLAIM PAST 24 MONTH FILING - HDR
2560	MEMBER SERVICES COVERED BY HMO PLAN
2561	PROVIDER INELIGIBLE FOR T19 SERVICES/HMO ONLY
2562	MEMBER PCPCM-CANNOT BILL OP/RHC/FQHC CLINICS RATE
	MEMBER NOT ENROLLED IN HMO FOR DOS
-	SUPPLEMENTAL DELIVERY PYMT DENIAL CODE
	EXCEPTION CODE 566
	HMO CO-PAY/NO TPL OR MEDICARE COVERAGE
	CC CLAIMS CAN'T PROCESS THRU SYSTEM
2570	INVALID ELIGIBILITY FOR HMO COPAY
	CLAIMCHECK REBUNDLED
	CC INCIDENTAL TO PRIMARY PROCEDURE
2573	CC MUTUALLY EXCLUSIVE

EOB Code De	
2574 CL	CLAIMCHECK COSMETIC SURGERY
	LAIMCHECK DUPLICATE
	C UNLISTED/OBSOLETE/EXPERIMENTAL/UNSPECIFIED
	LAIMCHECK POSSIBLE DUPLICATE
	LAIMCHECK PRE-OP/POST-OP
	C GROUPHEALTH SMARTSUSPENSE SUSPEND
	LAIMCHECK MEDICAL/EVALUATION VISIT
	MEMBER IS LOCKED-IN TO ANOTHER PHYSICIAN
	MEMBER IS LOCKED-IN TO ANOTHER PHARMACY
	LAIMREVIEW NEW VISIT FREQUENCY
	C GROUPHLTH SMARTSUSPENSE DENY
	LAIMREVIEW INTENSITY OF SERVICE
	TOP LOSS NOT APPROVED
	C INVALID MODIFIER/PROCEDURE COMBINATION
	LAIMCHECK EXCEEDS 40 LINES
	LAIMREVIEW MULTIPLE/DUPLICATE COMP.BILLING
	LAIMCEHCK AGE REPLACEMENT
	LAIM REVIEW DIAGNOSIS TO PROCEDURE
	LAIMCHECK-BILL EACH DOS ON A SEPARATE LINE
	LAIMCHECK AGE CONFLICT
	LAIMCHECK MULTIPLE SURGERY
	C-MULTIPLE SURGERY-DOUBLE MODIFIERS
	TOP LOSS THRESHOLD REACHED
	INITS NOT EQUAL TO TEETH BILLED
	ART A CROSSOVER SPANS 20020501
	INITS NOT EQUAL TO TEETH BILLED
	ROV ID ON CLAIM DOES NOT MATCH PROV ID ON PA
	ERVICE AND/OR DATES DO NOT MATCH PRIOR AUTH
	RIOR AUTH FUND AND CLAIM FUND DOES NOT MATCH
2606 PF	RIOR AUTH UNITS/AMOUNTS USED
2609 CH	HECK CLAIM ATTACHMENT
2612 TC	OOTH NUM ON CLAIM DOES NOT MATCH TOOTH NUM ON PA
2614 DI	IAG CODE MISSING/NOT ON FILE-INPATIENT CLAIMS
2615 CL	LINIC RATE NOT ON FILE FOR HOSPITAL
2616 PF	ROCEDURE NOT COMPENSABLE FOR ASSISTANT SURGEON
2618 Al	UTH SERVICES-MEMBER NOT ELIG
2619 M	/IEMBER INELIGIBLE PAY (AUTH EXAM) FROM STATE FUND
2620 M	MEDICARE ADJUSTED CLAIM-SUBMIT PAPER XOVER CLAIM
2622 M	MASS CREDIT/ADJ BEING SUSPEND
2623 A	DJUSTMENT HAS AUTO DENIAL
2625 FL	UND CODE UNDETERMINED
2627 CC	OVERED FOR ORAL PATH ONLY
2628 DF	RUG REQUIRES PRIOR AUTHORIZATION/MN
2630 DI	DIAGNOSIS NOT IN SCOPE OF DCYS PROGRAM
2631 DI	DIAGNOSIS NOT IN SCOPE OF CCP PROGRAM
2632 DI	DIAGNOSIS NOT IN SCOPE OF CN PROGRAM
2633 DI	DIAGNOSIS NOT IN SCOPE OF MN PROGRAM
2634 DE	ETAIL ATTENDING PHYSICIAN ID INVALID
2635 DE	PETAIL FIRST OTHER PHYSICIAN ID INVALID
2636 DE	PETAIL SECOND OTHER PHYS ID INVALID
2638 DF	RUG REQUIRES MEDICAL REVIEW/CN
2639 DF	RUG REQUIRES MEDICAL REVIEW/MN
2642 IN	NVALID PROVIDER NUMBER
2642	BORTION REQUIRES REVIEW
2643 AE	

FOB Code	Description
2646	PROVIDER RATE NOT ON FILE
2648	CC SITE SPECIFIC MODIFIER-FILE ON SEPARATE LINE
2649	FILE SEPARATE CLAIMS FOR JUNE/JULY HOSPITAL DAYS
2651	INVALID TREATMENT DIAGNOSIS INDICATOR
2652	PCS-INVALID NET CLAIM CHARGE
2653	MEMBER ID IS INVALID FOR AUTH EXAM
2654	MEMBER ID IS INVALID FOR AUTH EXAM PAY STATE FD
2655	ELIG CHANGES/FILE SEPARATE CLAIMS FOR EACH MONTH
2657	POTENTIAL DISABILITY CLAIM
2659	DATE OVER 1 YR MORE THAN 90 DAYS AFTER MEDICARE PD
2660	ZERO AMOUNT TO PAY
2673	SUBMIT PAPER CLAIM
2681	PROVIDER INELIGIBLE ON DATE OF SERVICE
2696	CROSSOVER PART A NOT PAYABLE MEDICALLY NEEDY
2697	QMB MEMBER ELIGIBLE FOR CROSSOVER ONLY
2701	PHYSICAN SIGNED CONSENT FORM BEFORE STERILIZATION
2702	DATE OF SURGERY ON CONSENT FORM IS NOT ON CLAIM
2702	MEMBER UNDER 21 WHEN SHE SIGNED CONSENT FORM
2704	REQUIRES ADDRESS FOR FACILITY FOR STERILIZATION
2705	STERILIZATION CONSENT FORM IS NOT LEGIBLE
2706	DATE ON THE CONSENT FORM IS NOT LEGIBLE
2707	STERILIZATION/HYSTERECTOMY CONSENT FORM IS MISSING
2707	PATIENT NAME ON CONSENT FORM DOES NOT MATCH CLAIM
2709	CONSENT LESS THAN 30 DAYS BEFORE STERILIZATION
2710	CONSENT MORE THAN 180 DAYS BEFORE STERILIZATION CONSENT MORE THAN 180 DAYS BEFORE STERILIZATION
2711	STERILIZATION CONSENT FORM NOT DATED BY PHYSICIAN
2711	CONSENT FORM IS NOT SIGNED BY THE MEMBER
2712	CONSENT FORM IS NOT SIGNED BY THE MEMBER CONSENT FORM IS NOT SIGNED BY THE COUNSELOR
2713	CONSENT FORM DOES NOT HAVE DATE COUNSELOR SIGNED
2715	STERILIZATION CONSENT FORM IS INCOMPLETE
2716	HYSTERECTOMY CONSENT FORM REQUIRED
2717	STERILIZATION CONSENT FORM NOT SIGNED BY PHYSICIAN
2718	INVALID SURGICAL PROCEDURE CODE
2719	REFILE CLAIM WITH OPERATIVE REPORT
2720	INCORRECT MEMBER DATE OF BIRTH ON CONSENT FORM
2721	FURTHER DESCRIPTION OF SERVICE REQUIRED
2722	STRENGTH AND DOSAGE OF INJECTION MEDICATION REQ
2723	SERVICES REQ DOCUMENTATION FOR MEDICAL NECESSITY
2724	REFILE CLAIM WITH CONSULTATION/PROGRESS NOTES
2725	SERVICE NOT COVERED AS BILLED
2726	REFERRING PHYSICIAN REQUIRED
2727	ANOTHER PROVIDER HAS BEEN PAID FOR THESE SERVICES
2728	SERVICES ARE NOT AUTHORIZED
2729	DENIED AFTER SPECIAL REVIEW
2730	HYSTERECTOMY CONSENT FORM SIGNED AFTER SURGERY
2732	COUNSELOR SIGNED CONSENT FORM PRIOR TO MEMBER
2733	SERVICES/SUPPLY NOT IN SCOPE OF PROGRAM
2734	PROCEDURE/REVENUE CODE-REQUIRE PRIOR AUTHORIZATION
2735	MEMBER INELIGIBLE ON SERVICE DATES
2736	MODIFIER ADDED/DELETED DUE TO MEDICAL REVIEW
2737	INVALID MODIFIER FOR THIS PROCEDURE
2738	INVALID PROCEDURE CODE USE VALID CPT OR HCPC CODE
2739	ONE AMBULATORY SURGERY ALLOWED PER DAY
2740	INVALID CODE FOR NARRATIVE DESCRIPTION
2741	INVALID SUBMITTED CHARGE

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2775 CLAIM HAS BEEN FORWARED TO HCA 2777 SHOW MEDICARE PART B PAYMENTS 2778 HEALTH CARE AUTHORITY PROCESSED ADM12 2779 ELIGIBILITY PROBLEM PROCESSED BY DHS 2780 RESUBMIT WITH APPROPRIATE VALUE CODE AND UNITS 2781 ANOTHER DDS PAID THIS SERVICE IN PREVIOUS 12 MONTH 2782 PART OF INPATIENT HOSPITAL CHARGES 2783 PROCEDURE INCLUDED IN OFFICE CALL 2785 ANOTHER PHARMACY PAID FOR THIS PRESCRIPTION 2786 SAME NDC/DATE PAID THIS DHARM 2787 ASST SURGEON MUST FILE OWN CLM 2788 CLINIC VISIT PAID THIS DATE 2789 PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN 2790 ABCDM-16/CLAIM PROV CONFLICT 2791 INVALID DIAGNOSIS FOR DESCRIPTION 2792 STERILIZATION CONSENT REQUIRED 2793 SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE 2794 PAID CLAIM INCLUDED THIS PROCEDURE 2795 CC MUTUALLY EXCLUSIVE 2796 PATIENT HAS PRIVATE INSURANCE 2797 MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2773	AUTHORIZED ROOM & BOARD SERVICES ARE NOT ON CLAIM
2777 SHOW MEDICARE PART B PAYMENTS 2778 HEALTH CARE AUTHORITY PROCESSED ADM12 2779 ELIGIBILITY PROBLEM PROCESSED BY DHS 2780 RESUBMIT WITH APPROPRIATE VALUE CODE AND UNITS 2781 ANOTHER DDS PAID THIS SERVICE IN PREVIOUS 12 MONTH 2782 PART OF INPATIENT HOSPITAL CHARGES 2783 PROCEDURE INCLUDED IN OFFICE CALL 2785 ANOTHER PHARMACY PAID FOR THIS PRESCRIPTION 2786 SAME NDC/DATE PAID THIS PHARM 2787 ASST SURGEON MUST FILE OWN CLM 2788 CLINIC VISIT PAID THIS DATE 2789 PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN 2790 ABCDM-16/CLAIM PROV CONFLICT 2791 INVALID DIAGNOSIS FOR DESCRIPTION 2792 STERILIZATION CONSENT REQUIRED 2793 SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE 2794 PAID CLAIM INCLUDED THIS PROCEDURE 2795 CC MUTUALLY EXCLUSIVE 2796 PATIENT HAS PRIVATE INSURANCE 2797 MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2774	EXCEPTION CODE 774
2778 HEALTH CARE AUTHORITY PROCESSED ADM12 2779 ELIGIBILITY PROBLEM PROCESSED BY DHS 2780 RESUBMIT WITH APPROPRIATE VALUE CODE AND UNITS 2781 ANOTHER DDS PAID THIS SERVICE IN PREVIOUS 12 MONTH 2782 PART OF INPATIENT HOSPITAL CHARGES 2783 PROCEDURE INCLUDED IN OFFICE CALL 2785 ANOTHER PHARMACY PAID FOR THIS PRESCRIPTION 2786 SAME NDC/DATE PAID THIS PHARM 2787 ASST SURGEON MUST FILE OWN CLM 2788 CLINIC VISIT PAID THIS DATE 2789 PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN 2790 ABCDM-16/CLAIM PROV CONFLICT 2791 INVALID DIAGNOSIS FOR DESCRIPTION 2792 STERILZATION CONSENT REQUIRED 2793 SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE 2794 PAID CLAIM INCLUDED THIS PROCEDURE 2795 CC MUTUALLY EXCLUSIVE 2796 PATIENT HAS PRIVATE INSURANCE 2797 MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2775	CLAIM HAS BEEN FORWARED TO HCA
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2780 RESUBMIT WITH APPROPRIATE VALUE CODE AND UNITS 2781 ANOTHER DDS PAID THIS SERVICE IN PREVIOUS 12 MONTH 2782 PART OF INPATIENT HOSPITAL CHARGES 2783 PROCEDURE INCLUDED IN OFFICE CALL 2785 ANOTHER PHARMACY PAID FOR THIS PRESCRIPTION 2786 SAME NDC/DATE PAID THIS PHARM 2787 ASST SURGEON MUST FILE OWN CLM 2788 CLINIC VISIT PAID THIS DATE 2789 PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN 2790 ABCDM-16/CLAIM PROV CONFLICT 2791 INVALID DIAGNOSIS FOR DESCRIPTION 2792 STERILIZATION CONSENT REQUIRED 2793 SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE 2794 PAID CLAIM INCLUDED THIS PROCEDURE 2795 CC MUTUALLY EXCLUSIVE 2796 PATIENT HAS PRIVATE INSURANCE 2797 MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2778	HEALTH CARE AUTHORITY PROCESSED ADM12
ANOTHER DDS PAID THIS SERVICE IN PREVIOUS 12 MONTH PART OF INPATIENT HOSPITAL CHARGES PROCEDURE INCLUDED IN OFFICE CALL ANOTHER PHARMACY PAID FOR THIS PRESCRIPTION SAME NDC/DATE PAID THIS PHARM ASST SURGEON MUST FILE OWN CLM CLINIC VISIT PAID THIS DATE PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN ABCDM-16/CLAIM PROV CONFLICT INVALID DIAGNOSIS FOR DESCRIPTION STERILIZATION CONSENT REQUIRED SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE PAID CLAIM INCLUDED THIS PROCEDURE CC MUTUALLY EXCLUSIVE PATIENT HAS PRIVATE INSURANCE MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2779	ELIGIBILITY PROBLEM PROCESSED BY DHS
PART OF INPATIENT HOSPITAL CHARGES PROCEDURE INCLUDED IN OFFICE CALL ANOTHER PHARMACY PAID FOR THIS PRESCRIPTION SAME NDC/DATE PAID THIS PHARM ASST SURGEON MUST FILE OWN CLM CLINIC VISIT PAID THIS DATE PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN ABCDM-16/CLAIM PROV CONFLICT INVALID DIAGNOSIS FOR DESCRIPTION STERILIZATION CONSENT REQUIRED SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE PAID CLAIM INCLUDED THIS PROCEDURE CC MUTUALLY EXCLUSIVE PATIENT HAS PRIVATE INSURANCE MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2780	RESUBMIT WITH APPROPRIATE VALUE CODE AND UNITS
PROCEDURE INCLUDED IN OFFICE CALL ANOTHER PHARMACY PAID FOR THIS PRESCRIPTION SAME NDC/DATE PAID THIS PHARM ASST SURGEON MUST FILE OWN CLM CLINIC VISIT PAID THIS DATE PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN ABCDM-16/CLAIM PROV CONFLICT INVALID DIAGNOSIS FOR DESCRIPTION STERILIZATION CONSENT REQUIRED SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE PAID CLAIM INCLUDED THIS PROCEDURE CC MUTUALLY EXCLUSIVE PATIENT HAS PRIVATE INSURANCE MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2781	ANOTHER DDS PAID THIS SERVICE IN PREVIOUS 12 MONTH
ANOTHER PHARMACY PAID FOR THIS PRESCRIPTION SAME NDC/DATE PAID THIS PHARM ASST SURGEON MUST FILE OWN CLM CLINIC VISIT PAID THIS DATE PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN ABCDM-16/CLAIM PROV CONFLICT INVALID DIAGNOSIS FOR DESCRIPTION STERILIZATION CONSENT REQUIRED SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE PAID CLAIM INCLUDED THIS PROCEDURE CC MUTUALLY EXCLUSIVE PATIENT HAS PRIVATE INSURANCE MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2782	PART OF INPATIENT HOSPITAL CHARGES
2786 SAME NDC/DATE PAID THIS PHARM 2787 ASST SURGEON MUST FILE OWN CLM 2788 CLINIC VISIT PAID THIS DATE 2789 PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN 2790 ABCDM-16/CLAIM PROV CONFLICT 2791 INVALID DIAGNOSIS FOR DESCRIPTION 2792 STERILIZATION CONSENT REQUIRED 2793 SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE 2794 PAID CLAIM INCLUDED THIS PROCEDURE 2795 CC MUTUALLY EXCLUSIVE 2796 PATIENT HAS PRIVATE INSURANCE 2797 MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2783	PROCEDURE INCLUDED IN OFFICE CALL
ASST SURGEON MUST FILE OWN CLM CLINIC VISIT PAID THIS DATE PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN ABCDM-16/CLAIM PROV CONFLICT INVALID DIAGNOSIS FOR DESCRIPTION STERILIZATION CONSENT REQUIRED SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE PAID CLAIM INCLUDED THIS PROCEDURE CC MUTUALLY EXCLUSIVE PATIENT HAS PRIVATE INSURANCE MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2785	ANOTHER PHARMACY PAID FOR THIS PRESCRIPTION
2788 CLINIC VISIT PAID THIS DATE 2789 PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN 2790 ABCDM-16/CLAIM PROV CONFLICT 2791 INVALID DIAGNOSIS FOR DESCRIPTION 2792 STERILIZATION CONSENT REQUIRED 2793 SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE 2794 PAID CLAIM INCLUDED THIS PROCEDURE 2795 CC MUTUALLY EXCLUSIVE 2796 PATIENT HAS PRIVATE INSURANCE 2797 MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2786	SAME NDC/DATE PAID THIS PHARM
PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN ABCDM-16/CLAIM PROV CONFLICT INVALID DIAGNOSIS FOR DESCRIPTION STERILIZATION CONSENT REQUIRED SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE PAID CLAIM INCLUDED THIS PROCEDURE CC MUTUALLY EXCLUSIVE PATIENT HAS PRIVATE INSURANCE MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2787	ASST SURGEON MUST FILE OWN CLM
2790 ABCDM-16/CLAIM PROV CONFLICT 2791 INVALID DIAGNOSIS FOR DESCRIPTION 2792 STERILIZATION CONSENT REQUIRED 2793 SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE 2794 PAID CLAIM INCLUDED THIS PROCEDURE 2795 CC MUTUALLY EXCLUSIVE 2796 PATIENT HAS PRIVATE INSURANCE 2797 MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2788	CLINIC VISIT PAID THIS DATE
2791 INVALID DIAGNOSIS FOR DESCRIPTION 2792 STERILIZATION CONSENT REQUIRED 2793 SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE 2794 PAID CLAIM INCLUDED THIS PROCEDURE 2795 CC MUTUALLY EXCLUSIVE 2796 PATIENT HAS PRIVATE INSURANCE 2797 MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2789	PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN
2792 STERILIZATION CONSENT REQUIRED 2793 SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE 2794 PAID CLAIM INCLUDED THIS PROCEDURE 2795 CC MUTUALLY EXCLUSIVE 2796 PATIENT HAS PRIVATE INSURANCE 2797 MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2790	ABCDM-16/CLAIM PROV CONFLICT
2793 SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE 2794 PAID CLAIM INCLUDED THIS PROCEDURE 2795 CC MUTUALLY EXCLUSIVE 2796 PATIENT HAS PRIVATE INSURANCE 2797 MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2791	INVALID DIAGNOSIS FOR DESCRIPTION
2794 PAID CLAIM INCLUDED THIS PROCEDURE 2795 CC MUTUALLY EXCLUSIVE 2796 PATIENT HAS PRIVATE INSURANCE 2797 MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2792	STERILIZATION CONSENT REQUIRED
2795 CC MUTUALLY EXCLUSIVE 2796 PATIENT HAS PRIVATE INSURANCE 2797 MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2793	SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE
2796 PATIENT HAS PRIVATE INSURANCE 2797 MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2794	PAID CLAIM INCLUDED THIS PROCEDURE
2797 MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS	2795	CC MUTUALLY EXCLUSIVE
	2796	PATIENT HAS PRIVATE INSURANCE
2700 DEELE WITH MEDICADE DECHECK HICANIAADED	2797	MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS
2/30 NEFILE WITH INICUICAKE KECHECK HIC NUIVIBEK	2798	REFILE WITH MEDICARE RECHECK HIC NUMBER

FOR Code	Description
2799	EXCEPTION CODE 799
2800	PHARMACY-EXACT DUPLICATE OF ANOTHER CLAIM
2801	PHARMACY-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2802	PHARMACY-POSSIBLE CONFLICT OF ANOTHER CLAIM
2803	DENTAL-EXACT DUPLICATE OF ANOTHER CLAIM
2804	DENTAL-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2806	PRACTITIONER-EXACT DUPLICATE OF ANOTHER CLAIM
2807	PRACTITIONER-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2808	MEMBER IS ELIGIBLE FOR HOSPICE FOR A PORTION OF THE DATES OF SERVICE BILLED. PLEASE CORRECT AND RESUBMIT.
2812	CROSSOVER-EXACT DUPLICATE OF ANOTHER CLAIM
2813	EXCEPTION CODE 813
2814	CROSSOVER-POSSIBLE CONFLICT OF ANOTHER CLAIM
2815	LTC-EXACT DUPLICATE OF ANOTHER CLAIM IN SYSTEM
2816	LTC-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2820	PCS-EXACT DUPLICATE OF ANOTHER CLAIM
2821	PCS-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2822	EXCEPTION CODE 822
2823	OUTPATIENT-EXACT DUPLICATE OF ANOTHER CLAIM
2824	OUTPATIENT-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2826	HOME HEALTH-EXACT DUPLICATE OF ANOTHER CLAIM
2827	EXCEPTION CODE 827
2828	HOME HEALTH-POSSIBLE CONFLICT OF ANOTHER CLAIM
2829	INPATIENT-EXACT DUPLICATE OF ANOTHER CLAIM
2830	INPATIENT-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2831	EXCEPTION CODE 831
2832	TRANSPORTATION-EXACT DUPLICATE OF ANOTHER CLAIM
2833	TRANSPORTATION-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2835	CHIROPRACTOR-EXACT DUPLICATE OF ANOTHER CLAIM
2836	CHIROPRACTOR-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2838	LAB/XRAY-EXACT DUPLICATE OF ANOTHER CLAIM
2839	LAB/XRAY-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2842	DEALER-EXACT DUPLICATE OF ANOTHER CLAIM
2843	DEALER-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2845	OPTOMETRIST-EXACT DUPLICATE OF ANOTHER CLAIM
2846	OPTOMETRIST-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2849	INVALID MODIFIER COMBINATION
2850	LTC/INPT POSSIBLE CONFLICT WITH INPT/LTC CLAIM
2851	LTC-HOME HEALTH CLAIM CONFLICT
2852	LTC-PCS POSSIBLE CONFLICT
2853	PCS-LTC POSSIBLE CONFLICT
2854	INPATIENT-PCS POSSIBLE CONFLICT
2855	PCS-INPATIENT POSSIBLE CONFLICT
2856	HH/INPT POSSIBLE CONFLICT WITH INPT/HH CLAIM
2857	INPT/CROSSOVER POSSIBLE CONFLICT CROSSOVER/INPT
2858	INPT/OUTPT POSSIBLE CONFLICT WITH OUTPT/INPT CLAIM
2859	EXCEPTION CODE 859
2860	CROSS CLAIM TYPE J CODE CONFLICT
2877	REVIEW EDITS 4005/4006/4009/4084 PRIOR TO CUTBACK
2880	PRODEDURE CODE NOT VALID FOR FORM
2881	HOME HEALTH-LTC CLAIM CONFLICT
2882	LTC/XOVER POSSIBLE CONFLICT WITH XOVER/LTC CLAIM
2883	CROSSOVER-PCS POSSIBLE CONFLICT
2884	PCS-CROSSOVER POSSIBLE CONFLICT
2889	PART-A COINSURANCE GREATER MEDICARE PD AMT
2890	REVIEW CROSSOVER PART B COINSURANCE OVER \$1000.00
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EOB Code	Description
2893	EXCEPTION CODE 893
2894	RURAL HEALTH REVENUE REQUIRES HCPC CODE
2895	RURAL HEALTH CLINIC REQUIRES REVENUE OP521
2896	FILE SEPARATE CLAIMS FOR DIFFERENT YEARS
2900	PCS DAYS REDUCED-INPT/LTC CONFLICT
2901	FILE SEPARATE CLAIM FOR REMAINING UNPAID DAYS
2903	MULTIPLE CPT CODES REQUIRED
2904	DENIED FOR OKLA FOUNDATION FOR PEER REVIEW AUDIT
2905	REFILE SEPARATE CLAIM FOR EACH MONTH
2906	MEDICARE DEDUCTIBLE APPLIED IN PREVIOUS 60 DAYS
2907	PAY TO GROUP HAS BEEN PAID FOR THIS SERVICE
2908	ANOTHER PROVIDER WITHIN GROUP PAID FOR SERVICE
2909	FILE SEPARATE CLAIM FOR SEPTEMBER AND OCTOBER
2910	PSYCHIATRIC ADMIT AFTER 9/1/92 NEEDS PA
2911	SERVICE PREVIOUSLY PAID ON GROSS ADJUSTMENT
2912	CLAIM HAS BEEN ADJUSTED AFTER SPECIAL REVIEW
2913	CLAIM HAS BEEN ADJUSTED AFTER MEDICAL REVIEW
2914	SERVICE PREVIOUSLY PAID ON PROVIDER ALTERNATE NUM
2915	PAID TO ANOTHER PROVIDER IN GROUP ON ALTERNATE NUM
2916	EXCEPTION CODE 916
2917	CHARGES INDICATE ERROR IN MATH
2917	INDICATE UNITS WORKED NOT DAYS
2919	FILE SEPARATE CLAIM FOR EACH DATE OF SERVICE
2919	WAIVERED SERVICE/DATES NOT ON PRIOR AUTHORIZATION
2921 2922	LIST EACH DATE SEPARATELY
	PATIENT RECEIVED SETTLE/BILL PATIENT
2923	ITEMIZE CHARGES FOR SUPPLIES CLIENT RESPONSIBLE EXCEEDS ALLOWABLE
2924	
2925	MEDICAL CONDITION/DIAGNOSIS NOT COVERED
2926	DME NAME BRAND DOES NOT MATCH ORDER NUMBER
2927	INDICATE EXACT UNITS PROVIDED FOR MEMBER
2928	WHOLESALER'S INVOICE REQUIRED FOR PAYMENT
2929	PROCEDURE LINITS REDUCED TO ALLOWARIE
2930 2931	PROCEDURE UNITS REDUCED TO ALLOWABLE
-	EXCEPTION CODE 931
2932	DUPLICATE OF PREVIOUSLY PAID CROSSOVER CLAIM
2933	ORIGINAL CLAIM BEING ADJUSTED-ALLOW 30 DAYS
2934	CLAIM WAS FILED WITH INVALID PROVIDER NUMBER
2935	RENTAL PREVIOUSLY PAID FOR THIS ITEM THIS MONTH
2936	CONTACT CASE MANAGER OR SUPERVISOR
2937	PROVIDER NOT ELIGIBLE THIS PROCEDURE CODE
2938	EXCEPTION CODE 938
2939	REFILE ON PAPER CLAIM
2940	SUBMIT PAPER CLAIM WITH NARRATIVE FOR PRICING
2941	REFILE WITH MEDICARE REMITTANCE STATEMENT
2942	DUPLICATE PAID THRU FINANCE
2943	REFILE ON ADM84-TRANSPORTATION CLAIM FORM
2944	DENIED AFTER CLAIM CHECK REVIEW
2945	INVALID PROOF OF DENIAL/HMO
2946	INVALID PROOF OF INSURANCE DENIAL
2947	REFILE WITH CORRECT ADMIT DATE
2948	RESUBMIT LEGIBLE CLAIM/ATTACHMENT
2949	EXCEPTION CODE 949
2950	THIS LEVEL TRANSPORTATION NOT REQUIRED
2951	DDSD WILL PROCESS CLAIM THROUGH FINANCE

FOR Code	Description
2952	REFILE-NAME BRAND & PRODUCT/ORDER NUMBER FOR PRICE
-	REFILE AS CROSSOVER WITH EOMP
	REFILE WITH APPROPRIATE EOMP
2955	NOT ELIGIBLE FOR WAIVERED SERVICES
2956	TPL PAID COLLECT FROM PATIENT
	NOT VERIFIED BY OPERATIVE REPORT
2958	ITEMIZE SURGERIES PER OPERATIVE REPORT
2959	CANNOT PROCESS NEGATIVE AMOUNTS
2960	ADJUSTED PER OFPR RECOMMENDATION
2961	NON EMERGENCY SERVICES NON PAYABLE FOR ALIEN
	DOCUMENT OF NECESSITY/MRI REPORT REQUIRED
2963	DOCUM DOES NOT JUSTIFY THE BILLED PROCEDURE
2964	REFILE CLAIM AS LIMIT TARGETED OB ULTRASOUND
	PAY REMAINING DAYS ON PARAMETER FILE
	FILE MEDICARE PART A FOR INPATIENT SERVICES
	PROVIDER NOT QUALIFIED FOR TARGETED OB US INTERP
2968	REFILE AS PHARMACY WITH NATIONAL DRUG CODE
	NO MEDICAL JUSTIFICATION FOR TARGETED OB US
	SUBMIT PREVIOUSLY REQUESTED OB/US QUALIFICATION
2971	PARTIAL HOURS NON ACCEPTABLE
2972	NO MEDICAL JUSTIFICATION FOR REVERSAL/REMOVAL
	REFILE AS AMBULATORY SURGERY
2974	PRESCRIBING PROVIDER EXCLUDED
2976	HYSTERECTOMY REQUIRE SIGN DATE
2977	REFILE CLAIM WITH MEDICAL RECORD
2978	INPATIENT HOSPITAL CLAIM PAID THIS DATE OF SERVICE
2979	NURSING HOME CLAIMS PAID THIS DATE OF SERVICE
2980	PROCEDURE NOT PAYABLE FOR THIS AGE
2981	VERIFY PA FOR THIS PROCEDURE/DATE OF SERVICE
2982	REFILE WITH PHYSICIAN PROGRESS NOTES
2983	PROV ID ON CLAIM DOES NOT MATCH PROV ID ON PA
2984	DIAGNOSIS NOT PAYABLE FOR NURSE MIDWIFE
2985	PROVIDER IS SUSPENDED OR TERMINATED
2986	UNITS CANNOT BE GREATER THAN 999
2987	PRIOR AUTHORIZATION UNITS/AMOUNTS USED
2988	TB ONLY ELIGIBLE - NEED 'T' IN FORCE FIELD (FF)
2989	SERVICE AND/OR DATES DO NOT MATCH PRIOR AUTH
2990	SERVICES ALLOWED AS ENCOUNTER ON ALTERNATE NUMBER
2991	UNITS REDUCED PER DOCU/AFTER SURS REVIEW
2993	EXCEPTION CODE 993
2994	EXCEPTION CODE 994
2995	EXCEPTION CODE 995
2996	EXCEPTION CODE 996
2997	EXCEPTION CODE 997
2998	EXCEPTION CODE 998
2999	EXCEPTION CODE 999
3000	UNITS EXCEED AUTHORIZED UNITS ON PRIOR AUTHORIZATION MASTER.
3001	PRIOR AUTHORIZATION DOES NOT MATCH FOR THIS CLAIM DETAIL.
3003	SERVICE REQUIRES PRIOR AUTHORIZATION.
3006	DOLLARS EXCEED AUTHORIZED DOLLARS ON AUTHORIZATION MASTER.
3037	MEMBER NUMBER HAS BEEN DEACTIVATED
3201	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR PRIMARY DIAGNOSIS.
3202	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR SECOND DIAGNOSIS.
3203	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR THIRD DIAGNOSIS.
3204	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR FOURTH DIAGNOSIS.

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3205	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR FIFTH DIAGNOSIS.
-	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR SIXTH DIAGNOSIS. CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR SIXTH DIAGNOSIS.
3207	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR SEVENTH DIAGNOSIS. CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR SEVENTH DIAGNOSIS.
3207	
3208	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR EIGHTH DIAGNOSIS.
	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR NINTH DIAGNOSIS.
3210	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TENTH DIAGNOSIS.
3211	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR ELEVENTH DIAGNOSIS.
3212	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWELFTH DIAGNOSIS.
3213	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR THIRTEENTH DIAGNOSIS.
3214	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR FOURTEENTH DIAGNOSIS.
3215	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR FIFTEENTH DIAGNOSIS.
3216	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR SIXTEENTH DIAGNOSIS.
3217	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR SEVENTEENTH DIAGNOSIS.
3218	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR EIGHTEENTH DIAGNOSIS.
3219	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR NINETEENTH DIAGNOSIS.
3220	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTIETH DIAGNOSIS.
3221	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTY-FIRST DIAGNOSIS.
3222	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTY-SECOND DIAGNOSIS.
3223	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTY-THIRD DIAGNOSIS.
3224	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTY-FOURTH DIAGNOSIS.
3225	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTY-FIFTH DIAGNOSIS.
3226	CLAIM DETAIL DENIED. UNITS OF SERVICE EXCEED NCCI MUE LIMITATION FOR THIS DMESUPPLIER SERVICE. THIS DENIED SERVICE
3227	CLAIM DETAIL DENIED. UNITS OF SERVICE EXCEED NCCI MUE LIMITATION FOR THIS SERVICE. THIS DENIED SERVICE SHOULD NOT BE
3228	CLAIM DETAIL DENIED. UNITS OF SERVICE EXCEED NCCI MUE LIMITATION FOR THIS OUTPATIENT HOSPITAL SERVICE. THIS DENIED
3229	CLAIM/DETAIL DENIED. DIAGNOSIS CODE INVALID FOR THIS DRUG.
3230	MEDICAL DIRECTION FOR ANESTHESIA IS NOT COVERED.
3233	CLAIM/DETAIL DENIED. NOT ALLOWED TO SUBMIT EVV SERVICES.
3234	CLAIM/DETAIL DENIED. ATTACHMENT NOT RECEIVED.
3236	MEDICARE COPAY + COINSURANCE + DEDUCTIBLE GREATER THAN ESTABLISHED LIMIT. PLEASE VERIFY THE AMOUNT(S) YOU
3237	NO MATCHING EVV RECORD FOUND FOR THIS SERVICE.
3238	CLAIM SERVICE UNITS EXCEED THE EVV UNITS.
3301	TOTAL CLAIM BILLED EXCEEDS DOLLAR LIMIT (\$99,000)
3315	NURSING FACILITY RATE NOT ON FILE FOR THE DATE OF SERVIVE(S) BILLED.
3340	UB-04 CLAIMS MUST INCLUDE AT LEAST ONE VALID REVENUE CODE.
3354	LTC PROVIDER NUMBER MUST BE ENTERED.
3360	TAXONOMY CODE INVALID
3362	PA NUMBER OR PA PAYMENT METHOD IS NOT VALID
3371	THE DISCHARGE HOUR IS MISSING OR INVALID.
3382	THIS DIAGNOSIS IS NOT PAYABLE FOR THIS PROVIDER TYPE.
3385	MODIFIER IS INVALID FOR MEMBER'S GENDER.
3398	SERVICE(S) NOT COVERED BY KY MEDICAID. DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.
3399	SERVICE NOT COVERED FOR THE RENDERING PROVIDER NUMBER.
3400	RENDERING PROVIDER TYPE INVALID FOR GROUP/CLINIC
3402	THE FOLLOWING CODES ARE REIMBURSED THROUGH THE PHARMACY PROGRAM: A4206, A4210,A4250, A4252, A4253, A4256,
3404	THE BILLING PROVIDER IS NOT ENROLLED TO THE MCO.
3405	PATIENT ACCOUNT NUMBER MUST BE ENTERED IN THE MEDICAL RECORD NUMBER FIELD ON PROFESSIONAL AND INSTITUTIONAL
3406	DELIVERY DIAGNOSES INCOMPLETE WITHOUT A REPORT OF PREGNANCY WEEKS OF GESTATION.PLEASE RESUBMIT WITH DIAGNOSIS
3407	EARLY DELIVERY NOT PAYABLE FOR THIS DIAGNOSIS CODE(S). PLEASE RESUBMIT WITH MEDICAL DOCUMENTATION SHOWING
3408	PHYSICIAN ADMINISTERED DRUG RATES ARE NOT ON FILE FOR THIS PROCEDURE CODE/NDC COMBINATION.
3409	PHYSICIAN ADMINISTERED DRUG (PAD) PROCEDURE CODE REQUIRES NDC.
3410	NDC NOT VALID FOR PHYSICIAN ADMINISTERED DRUG (PAD) PROCEDURE CODE.
3411	NDC IS RATED DESI.
3412	NDC IS NOT REBATE-ELIGIBLE.
3413	NDC NOT VALID FOR DATE OF SERVICE.
3414	NDC IS OBSOLETE.

MINTS OF SERVICE CONNOT EXCEED THE NUMBER OF DETAIL DAYS BILLED AND CANNOTINCLUDE DISCHARGE DATE. ALLE ARVENUE CODE 169 MAY NOT BE BILLED WITH OTHER ACCOMMODATION REVENUE CODES. REVENUE CODE 169 MAY NOT BE BILLED WITH OTHER ACCOMMODATION REVENUE CODES. CEGINC CLAIM HAS ERRORS. PLASE CORRECT ALL ERRORS AND RESUBMIT THE ENTIRE CLAIM. THIS PROCEDURE CODE REQUIRES AN INC. THE NOT SIM SIMBLY OF INC. AND THIS PROCEDURE CODE REQUIRES AN ADD. THE NOT SIMBLY OF INC. AND THIS PROCEDURE CODE REQUIRES AN ADD. MODIFIER OJS NOT SILLABLE ON COMMUNITY MENTAL HEALTH CENTER CLAIMS. PROCEDURE CODE TIONO IS NOT BILLABLE FOR COMMUNITY MENTAL HEALTH CENTER (PROVIDER TYPE 30) SERVICES. AND MODIFIER OJS NOT SILLABLE ON COMMUNITY MENTAL HEALTH CENTER (PROVIDER TYPE 30) SERVICES. AND MODIFIER OJS NOT SILLABLE ON COMMUNITY MENTAL HEALTH CENTER (PROVIDER TYPE 30) SERVICES. AND MODIFIER OJS NOT SILLABLE WITH CENTAN PROCEDURE CODE 9901. FAILS TO MEET DAYS CRITERIA, PLEASE CONTACT DMS AT DMSSPHARMACYGRY. GOV. MODIFIER 33 IS OUNLY BILLABLE WITH CERTAIN PROCEDURE CODE 905 OR PROCEDURE CODE/DIAGNOSIS CODE/AGE/GENDER. MODIFIER 33 IS ONLY BILLABLE WITH CERTAIN PROCEDURE CODES OR PROCEDURE CODE/DIAGNOSIS CODE/AGE/GENDER. MODIFIER 33 IS ONLY BILLABLE WITH CERTAIN PROCEDURE CODES OR PROCEDURE CODE/DIAGNOSIS CODE/AGE/GENDER. MODIFIER 53 IN DIAGNOSIS ONLY BILLABLE WITH CERTAIN PROCEDURE IS IN EXCESS OF THE THRESHOLD SETBY DMS TO AUTOMATICALLY INITIATE A 1939 OFTEN LIBER SHIP, LIBER	FOR Code	Description
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3418 INTERFEDITION OF THE PROCEDURE OR DECIDIES AND NO. THE BOT IS MISSING OR IS NOT ON FILE. 3420 ARESTHESIA PROCEDURES REQUIRE AN APPROPRIATE MODIFIER 3421 MODIFIER C2 IS NOT BILLABLE OR COMMUNITY MENTAL HEATTH CENTER (PROVIDER TYPE 30) SERVICES. 3422 MODIFIER C3 IS NOT BILLABLE OR COMMUNITY MENTAL HEATTH CENTER (PROVIDER TYPE 30) SERVICES. 3423 MODIFIER C8 DO NIT ALLOWED WITH PROCEDURE CODE 99401. 3424 FAILS TO MEET DMS: GRITERIA, PLEASE CONTIACT DMS AT DUST-PLANCE WE WITH PROCEDURE CODE 19401. 3425 MODIFIER C8 DNIT ALLOWED WITH PROCEDURE CODE 99401. 3426 FAILS TO MEET DMS: GRITERIA, PLEASE CONTIACT DMS AT DUST-PLANCE WE WE WITH PROCEDURE CODE 19401. 3427 FOR ADDITION OF MEET DMS: GRITERIA, PLEASE CONTIACT DMS AT DUST-PLANCE WE WE WE WE WE WE WITH PROCEDURE CODE 19401. 3428 FAILS TO MEET DMS: GRITERIA, PLEASE CONTIACT DMS AT DUST-PLANCE WE		
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4064 GENDER RESTRICTION FOR COVERED ICD PROCEDURE.	4063	ICD PROCEDURE CODE/AGE RESTRICTION.
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### EPOGEN REQUIRES VALUE CODE 68 #### THIS REVENUE CODE IS NOT COVERED FOR THIS MEMBER. ###################################	4216	SUBMITTED CLIA NUMBER DOES NOT HAVE CORRECT CERTIFICATION.
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MODIFIER U1 IS NOT VALID FOR PHYSICIAN CLAIMS FOR DATES OF SERVICE 10/01/2015 AND AFTER. PHYSICIAN ASSISTANT SERVICES MODIFIERS AS AND 80 CANNOT BE BILLED WITH MODIFIER SA. MODIFIER AS ALLOWED FORDOS 11/01/2023, AND AFTER. MODIFIER BILLED IS NOT COVERED FOR THIS PROVIDER TYPE. CLAIM REQUIRES DOCUMENTATION. PLEASE RESUBMIT ON PAPER. DOCUMENTATION REQUIRED DEPENDENT ON SPECIFIC	4433	TYPE OF BILL INVALID FOR CLAIM TYPE.
 MODIFIERS AS AND 80 CANNOT BE BILLED WITH MODIFIER SA. MODIFIER AS ALLOWED FORDOS 11/01/2023, AND AFTER. MODIFIER BILLED IS NOT COVERED FOR THIS PROVIDER TYPE. CLAIM REQUIRES DOCUMENTATION. PLEASE RESUBMIT ON PAPER. DOCUMENTATION REQUIRED DEPENDENT ON SPECIFIC 	4434	MODIFIER 50 CANNOT BE BILLED WITH UNITS OF SERVICE GREATER THAN 1.
 MODIFIER BILLED IS NOT COVERED FOR THIS PROVIDER TYPE. CLAIM REQUIRES DOCUMENTATION. PLEASE RESUBMIT ON PAPER. DOCUMENTATION REQUIRED DEPENDENT ON SPECIFIC 	4435	MODIFIER U1 IS NOT VALID FOR PHYSICIAN CLAIMS FOR DATES OF SERVICE 10/01/2015 AND AFTER. PHYSICIAN ASSISTANT SERVICES
CLAIM REQUIRES DOCUMENTATION. PLEASE RESUBMIT ON PAPER. DOCUMENTATION REQUIRED DEPENDENT ON SPECIFIC	4436	MODIFIERS AS AND 80 CANNOT BE BILLED WITH MODIFIER SA. MODIFIER AS ALLOWED FORDOS 11/01/2023, AND AFTER.
	4437	MODIFIER BILLED IS NOT COVERED FOR THIS PROVIDER TYPE.
4439 CCBHC SERVICES BILLED FOR SCHIP MEMBERS ARE NOT PAYABLE.	4438	CLAIM REQUIRES DOCUMENTATION. PLEASE RESUBMIT ON PAPER. DOCUMENTATION REQUIRED DEPENDENT ON SPECIFIC
	4439	CCBHC SERVICES BILLED FOR SCHIP MEMBERS ARE NOT PAYABLE.

FOR Code	Description
4440	DIAGNOSIS CODE(S) DOES NOT SUPPORT PROCEDURE CODE BILLED.
4714	AGE RESTRICTION FOR BILLED PROCEDURE.
4715	AGE RESTRICTION FOR BILLED REVENUE CODE.
4750	REVENUE CODE NOT COVERED FOR THIS MEMBER AND TYPE OF BILL.
4760	MEDICAL REVIEW RESTRICTION FOR BILLED ICD PROCEDURE.
4765	THIS ICD PROCEDURE IS NOT COVERED FOR THIS MEMBER.
4801	THIS PROCEDURE IS NOT COVERED FOR THIS PROVIDER CONTRACT.
4802	THE PROVIDER IS NOT ALLOWED TO BILL THIS DIAGNOSIS
4804	THIS REVENUE CODE IS NOT COVERED FOR THIS PROVIDER CONTRACT.
4805	THIS DRG IS NOT COVERED FOR THIS PROVIDER CONTRACT.
4813	MUST SUBMIT SPECIFIC DOCUMENTATION WHICH SUPPORTS THE PROCEDURE BEING PERFORMEDIN THIS SETTING VS. THE
4831	NO REIMBURSEMENT RULE ON FILE.
4882	THIS DRG IS NOT COVERED FOR THIS MEMBER.
4886	DENIED. DRG IS NOT COVERED.
4975	THIS REVENUE CODE IS NOT COVERED FOR THIS MEMBER.
4980	MEMBER BENEFIT AND ASSIGNMENT PLANS CONFLICT WITH EACH OTHER.
4990	THIS PROCEDURE CODE IS NOT COVERED FOR THIS MEMBER.
5000	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5001	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5002	THIS ADJUSTMENT IS A DUPLICATE OF A PREVIOUS ADJUSTMENT.
5003	THIS IS A DUPLICATE OF ANOTHER CLAIM REVERSAL.
5004	REVERSAL NOT PROCESSED, NO MATCH FOUND ON RX NUMBER AND PROVIDER NUMBER. PLEASE REFER TO YOUR POS MANUAL.
5005	REVERSAL NOT PROCESSED- MULTIPLE MATCHES FOUND WITH SAME RX NUMBER, PROVIDER NUMBER AND DISPENSING DATE.
5007	THIS IS A DUPLICATE OF ANOTHER CLAIM. IF THIS CLAIM WAS INTENDED TO BE AN ADJUSTMENT, PLEASE SUBMIT THE APPROPRIATE
5010	EXACT DUPLICATE - TOOTH SURFACE
5017	ALL CCBHC SERVICES FOR THE SAME PROVIDER/MEMBER/DATE OF SERVICE COMBINATION MUST BE SUBMITTED ON A SINGLE
5100	MAXIMUM HOSPITAL DAYS FOR THIS ADULT HAVE BEEN PAID. NO ADDITIONAL VISITS WILL BE ALLOWED.
5101	PRICING ADJUSTMENT. CLAIM WAS PRICED AT A REDUCED RATE (99213)
5102	PRICING ADJUSTMENT. CLAIM WAS PRICED AT A REDUCED RATE (99348)
5110	CLAIM DETAIL DENIED. MUST BILL INTRAORAL COMPLETE SERIES
5111	ENVIRONMENTAL ACCESSIBILITY SERVICES PAYMENT LIMITED TO \$8,800.00 FOR THIS TIMEPERIOD.
5112	ENVIRONMENTAL ACCESSIBILITY SERVICES PAYMENT LIMITED TO \$9,680.00 FOR THIS TIMEPERIOD.
5113	T2025 IS LIMITED TO \$1,100.00 DURING AN SCL2 MEMBER?S PLAN OF CARE PERIOD.
5114	T2025 IS LIMITED TO \$1,210.00 DURING AN SCL2 MEMBER'S PLAN OF CARE PERIOD.
5122	PROCEDURE CODE L3030 IS LIMITED TO TWO PER LEG PER MEMBER PER CALENDAR YEAR.
5200	VENI/ARTERIAL PUNCTURE SAME DATE OF SERVICE AS MONITORED PROCEDURE.
5203	CBC MAY NOT BE PAID ON SAME DAY AS CBC COMPONENTS.
5214	PROCEDURE CODES 93297 AND 93298 NOT ALLOWED SAME DOS.
5217	PROCEDURE CODES 93285 AND 93279, 93284 OR 93291 NOT ALLOWED SAME DOS.
5219	PROCEDURE CODE 93286 OR 93288 AND 93279-93281 NOT ALLOWED SAME DOS.
5221	PROCEDURE CODE 93287 OR 93289 AND 93282-93284 NOT ALLOWED SAME DOS.
5222	PROCEDURE CODE 93288 AND 93286, 93294, OR 93296 NOT ALLOWED SAME DOS.
5223	PROCEDURE CODE 93289 AND 93287, 93295 OR 93296 NOT ALLOWED SAME DOS.
5224	PROCEDURE CODE 93290 AND 93297 OR 93299 NOT ALLOWED SAME DOS.
5235	PROC S5100 & REV 580 NOT BILLABLE SAME MEMBER SAME DOS
5236	MONTHLY DIALYSIS NOT PAYABLE FOR SAME DATE OF SERVICE AS DAILY.
5237	PROCEDURE CODE 93293 AND 93294 NOT ALLOWED SAME DOS.
5241	PROCEDURES ARE NOT PAYABLE IN 30 DAYS OF RELATED PROCEDURES.
5242	PROCEDURE CODE 93291 AND 93288-93290, 93298 OR 93299 NOT ALLOWED SAME DOS.
5244	PROCEDURE CODE 93296 AND 93299 NOT ALLOWED SAME DOS.
5246	PROCEDURE CODES 93282 OR 93292 AND 93745 NOT ALLOWED SAME DOS.
5249	PROCEDURE CODE 93285 OR 93291 AND 33282 NOT ALLOWED ON THE SAME DOS.
5250	PROCEDURE CODE H0050 IS NOT ALLOWED ON THE SAME DOS AS PROCEDURE CODE H0001, 90791, 90792, 90845, 96105, 96110,
5263	RESPITE AND PERSONAL SERVICES CANNOT BE BILLED ON THE SAME DATE OF SERVICE AS RESIDENTIAL SERVICES.
5265	THERAPY SERVICES PERFORMED BY A THERAPIST CANNOT BE BILLED ON THE SAME DATE OFSERVICE AS THERAPY SERVICES

PROCEDURE CODES H2019 AND H2020 NOT ALLOWED ON THE SAME DATE OF SERVICE, SAME MEMBER. 2779 PROCEDURE CODE H2019 AND H2020 NOT ALLOWED ON THE SAME DATE OF SERVICE, SAME MEMBER. 2771 PROCEDURE CODE H2019 AND H2020 NOT ALLOWED ON THE SAME DATE OF SERVICE, SAME MEMBER. 2772 PROCEDURE CODE NOT ALLOWED FOR DOS AS ADDITIONAL PROCEDURE. 2773 DETAIL DENIED, PROCEDURE CODE IS NOT ALLOWED FOR THE SAME DATE OF SERVICE, SAME PROVIDER, SAME DATE OF SERVICE AS OTHER MEMBER. 2773 DETAIL DENIED, PROCEDURE CODE IS NOT ALLOWED FOR THE SAME MEMBER, SAME PROVIDER, SAME DATE OF SERVICE AS OTHER MEMBER. 2775 MILEAGE NOT ALLOWED ON THE SAME DATE OF SERVICE AS AG998. 2786 CEVERAL SERVICES NOT PAYABLE ON SAME DOS AS SPECIAL. 2797 SILOWAND SAME ON THE SAME DATE OF SERVICE AS AG998. 2798 FROCEDURE CODE P3030 AND PROCEDURE CODE H3030, MIGDIFIER UG, ARE NOT ALLOWED ON THE SAME DOS, SAME MEMBER. 2799 PROCEDURE CODES 500170 AND D3220 NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THESAME MEMBER. 2799 PROCEDURE CODES 500170 AND D3220 NOT PAYABLE ON SAME DATE OF SERVICE FOR THESAME MEMBER. 2799 PROCEDURE CODES 500170 AND D3220 NOT PAYABLE ON SAME DATE OF SERVICE FOR THESAME MEMBER. 2799 PROCEDURE CODES 500170 AND D3220 NOT PAYABLE ON SAME DATE OF SERVICE FOR THESAME MEMBER. 2799 PROCEDURE CODES 500170 AND D3220 NOT PAYABLE ON SAME DATE OF SERVICE FOR THESAME MEMBER. 2799 PROCEDURE CODES 500170 AND D3220 NOT PAYABLE ON SAME DATE OF SERVICE FOR THESAME MEMBER. 2790 PROCEDURE CODES 500170 AND D3220 NOT PAYABLE ON SAME DATE OF SERVICE FOR THESAME MEMBER. 2709 PROCEDURE CODES 500170 AND D3220 NOT PAYABLE ON SAME DATE OF SERVICE FOR SERVICE, SAME MEMBER, SAME 2709 PROCEDURE CODES 500170 AND D3220 NOT PAYABLE ON SERVICE AS 500170 PAYABLE WHITE SAME DATE OF SERVICE AS 72192-72194, 74150-74170, 74263, 76376, PROCEDURE CODES 500170 AND D3240 A	EOB Code	Description
99110/09110 ON SAME DOS AS OTHER PROCEDURE. 3277 PROCEDURE CODE PLOS AND HORDOO TO ALLOWED ON THE SAME DATE OF SERVICE, SAME MEMBER. 3278 PROCEDURE CODE NOT SEMBLISHES HERIMBURSEMENT FOR SURGERY. 3279 PROCEDURE CODE NOT SEMBLISHES HERIMBURSEMENT FOR SURGERY. 3279 PROCEDURE CODE NOT ALLOWED FOR DOS AS ADDITIONAL PROCEDURE. 3273 PROCEDURE CODE NOT SEMBLISHES HERIMBURSEMENT FOR SURGERY. 3275 PROCEDURE CODE NOT SEMBLISHES HERIMBURSEMENT FOR SURGERY. 3276 PROCEDURE CODE NOT SEMBLISHES ON SAME DOS AS SPECIAL. 3277 PROCEDURE CODE 12019 AND DEPOCEDURE CODE HORD SERVICE AS OTHER MEMBER, SAME PROVIDER, SAME DATE OF SERVICE AS OTHER MEMBER. 3281 PROCEDURE CODE 12019 AND PROCEDURE CODE HORD SEMBLISHES AND SEMBLISHES. 3292 PROCEDURE CODE DETAILS SAME HEMBER SAME DOS SURGERY. 3293 PROCEDURE CODES 1010 BILLARIE SAME MEMBER SAME DOS SURGERY. 3294 PROCEDURE CODES DOS SAME DOS AS SEVENAL AND SEMBLISHES SEMBLISHES. 3295 PROCEDURE CODES SON SON DE PAYABLE ON SAME DOS. 3206 PROCEDURE CODES SON SON DE PAYABLE ON SAME DOS. 3207 PROCEDURE CODES SON SON DE PAYABLE ON SAME DOS. 3208 ADDITIONAL SERVICE COSES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. 3209 PROCEDURE CODES SON SON DE PAYABLE ON SAME DOS. 3200 ADDITIONAL SERVICE COSES MUST BE SILVED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. 3200 ADDITIONAL SERVICE COSES MUST BE SILVED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. 3201 CALAMD DENIED JOS SAME DOT PAYABLE ON SAME DATE OF SERVICE AS 757912-72194, 74150-74170, 74263, 76376, CRANGERY SAME PAYABLE ON SAME DATE OF SERVICE AS 95580 OR 75950. 3201 CALAMD DENIED JOS SAME DATE OF SERVICE AS 95580 OR 75950. 3202 CALAMD DENIED JOS SAME DATE OF SERVICE AS 95580 OR 75959. 3203 CALAMD DENIED JOS SAME DATE OF PAYABLE ON THE SAME DATE OF SERVICE AS 95393. 3204 CALAMD DENIED JOS SAME DATE ON THE SAME DATE OF SERVICE AS 95393. 3205 CALAMD DENIED JOS SAME DATE ON THE SAME DATE OF SERVICE AS 95393. 3206 CALAMD DENIED JOS SAME DATE ON THE SAME DATE OF SERVICE AS 95393. 3207 CALA		
PAYMENT FOR PROCEDURE SIN REIMBURSEMENT FOR SURGERY. 2772 PROCEDURE CODE NOT ALLOWED FOR DOS AS ADDITIONAL PROCEDURE. 2773 DETAIL DENIED. PROCEDURE CODE IS NOT ALLOWED FOR THE SAME MEMBER, SAME PROVIDER, SAME DATE OF SERVICE AS AD998 2775 MILEAGE NOT ALLOWED ON THE SAME DATE OF SERVICE AS A0998 2776 SEMERAL SERVICES NOT PAYABLE ON SAME DOS AS SPECIAL. 2787 SEMERAL SERVICES NOT PAYABLE ON SAME DOS AS SPECIAL. 2788 PROCEDURE CODE OBTION AND PROCEDURE CODE HZOLD, MODIFIER LIG, ARE NOT ALLOWED ONTHE SAME DOS, SAME MEMBER. 2790 SSIOO AND SSIOL NOT BILLABLE SAME MEMBERS RAME DOS 2791 HEMODIALYSIS NOT PAYABLE ON SAME DOS AS EVALUATION PROCEDURE. 2792 HEMODIALYSIS NOT PAYABLE ON SAME DOS. 2793 PROCEDURE CODES OLD AND PAYABLE ON SAME DOS. 2794 PROCEDURE CODES OLD AND PAYABLE ON SAME DOS. 2795 PROCEDURE CODES OLD SAME DOS AS EVALUATION PROCEDURE. 2795 PROCEDURE CODES OLD SAME DOS AS EVALUATION PROCEDURE. 2796 PROCEDURE CODES OLD SAME DOS AS EVALUATION PROCEDURE. 2797 PROCEDURE CODES OLD SAME DOS AS EVALUATION PROCEDURE. 2798 PROCEDURE CODES OLD SAME DOS AS EVALUATION WITH OTHER SPECIFIED PROCEDURE CODES. 2799 PROCEDURE CODES OLD SAME DOS AS EVALUATION WITH OTHER SPECIFIED PROCEDURE CODES. 2799 PROCEDURE CODES OLD SAME DOS AS EVALUATION WITH OTHER SPECIFIED PROCEDURE CODES. 2799 PROCEDURE CODES OLD SAME DOS AS EVALUATION WITH OTHER SPECIFIED PROCEDURE CODES. 2799 PROCEDURE CODES OLD SAME DOS AS EVALUATION WITH OTHER SPECIFIED PROCEDURE. 2799 PROCEDURE CODES OLD SAME DOS AS EVALUATION WITH OTHER SPECIFIED PROCEDURE. 2799 PROCEDURE CODES OLD SAME DOS AS EVALUATION. 2790 PROCEDURE CODE SAME SAME SAME DOS AS EV	5269	
PAYMENT FOR PROCEDURE SIN REIMBURSEMENT FOR SURGERY. 2772 PROCEDURE CODE NOT ALLOWED FOR DOS AS ADDITIONAL PROCEDURE. 2773 DETAIL DENIED. PROCEDURE CODE IS NOT ALLOWED FOR THE SAME MEMBER, SAME PROVIDER, SAME DATE OF SERVICE AS AD998 2775 MILEAGE NOT ALLOWED ON THE SAME DATE OF SERVICE AS A0998 2776 SEMERAL SERVICES NOT PAYABLE ON SAME DOS AS SPECIAL. 2787 SEMERAL SERVICES NOT PAYABLE ON SAME DOS AS SPECIAL. 2788 PROCEDURE CODE OBTION AND PROCEDURE CODE HZOLD, MODIFIER LIG, ARE NOT ALLOWED ONTHE SAME DOS, SAME MEMBER. 2790 SSIOO AND SSIOL NOT BILLABLE SAME MEMBERS RAME DOS 2791 HEMODIALYSIS NOT PAYABLE ON SAME DOS AS EVALUATION PROCEDURE. 2792 HEMODIALYSIS NOT PAYABLE ON SAME DOS. 2793 PROCEDURE CODES OLD AND PAYABLE ON SAME DOS. 2794 PROCEDURE CODES OLD AND PAYABLE ON SAME DOS. 2795 PROCEDURE CODES OLD SAME DOS AS EVALUATION PROCEDURE. 2795 PROCEDURE CODES OLD SAME DOS AS EVALUATION PROCEDURE. 2796 PROCEDURE CODES OLD SAME DOS AS EVALUATION PROCEDURE. 2797 PROCEDURE CODES OLD SAME DOS AS EVALUATION PROCEDURE. 2798 PROCEDURE CODES OLD SAME DOS AS EVALUATION WITH OTHER SPECIFIED PROCEDURE CODES. 2799 PROCEDURE CODES OLD SAME DOS AS EVALUATION WITH OTHER SPECIFIED PROCEDURE CODES. 2799 PROCEDURE CODES OLD SAME DOS AS EVALUATION WITH OTHER SPECIFIED PROCEDURE CODES. 2799 PROCEDURE CODES OLD SAME DOS AS EVALUATION WITH OTHER SPECIFIED PROCEDURE CODES. 2799 PROCEDURE CODES OLD SAME DOS AS EVALUATION WITH OTHER SPECIFIED PROCEDURE. 2799 PROCEDURE CODES OLD SAME DOS AS EVALUATION WITH OTHER SPECIFIED PROCEDURE. 2799 PROCEDURE CODES OLD SAME DOS AS EVALUATION. 2790 PROCEDURE CODE SAME SAME SAME DOS AS EV	5270	PROCEDURE CODE H2019 AND H2020 NOT ALLOWED ON THE SAME DATE OF SERVICE, SAME MEMBER.
PROCEDURE CODE NOT ALLOWED FOR DOS AS ADDITIONAL PROCEDURE. 2773 DETAIL DENIED. PROCEDURE CODE IS NOT ALLOWED FOR THE SAME MEMBER, SAME PROVIDER, SAME DATE OF SERVICE AS OTHER. 2774 MILEAGE NOT ALLOWED ON THE SAME DATE OF SERVICE AS A0998. 2786 SERVERAL SERVICES NOT PAYABLE ON SAME DOS AS SPECIAL. 2787 SERVICE AS A0199 AND PROCEDURE CODE 12015, MODIFIER UG, ARE NOT ALLOWED ONTHE SAME DOS, SAME MEMBER. 2898 S3200 AND S3201 NOT BILLABLE SAME MEMBER SAME DOS. 2992 HEMODIALYSIS NOT PAYABLE ON SAME DOS AS EVALUATION PROCEDURE. 2995 PROCEDURES CODES 00170 AND D9220 NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THESAME MEMBER. 2995 PROCEDURE CODES 00170 AND D9220 NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THESAME MEMBER. 2997 PROCEDURE CODES 00170 AND D9220 NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THESAME MEMBER. 2998 PROCEDURE CODES 00170 AND D9220 NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THESAME MEMBER. 2909 PROCEDONTAL SACIUMS AND ROOT PAYABLE ON SAME DOS. 3000 ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. 3010 PRISODONTAL SACIUMS AND ROOT PAYABLE ON THE SAME DOS. 2012 PRISODONTAL SACIUMS AND ROOT PAYABLE ON SAME DATE OF SERVICE, SAS SERVICE, SAME MEMBER, SAME 3030 CLAIM DENIED. 39581 NOT PAYABLE ON THAT OF SERVICE AS 295440 OR 39580. CLAIM DENIED. 39581 NOT PAYABLE ON THAT OF SERVICE AS 395840 OR 39580. CLAIM DENIED. 39581 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 395840 OR 39580. CLAIM DENIED. 39581 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 395840 OR 39594. 3010 CLAIM DENIED. 39591 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 395890-39394. CLAIM DENIED. 39591 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 39594, 39394, 39393, 39394. 3011 CLAIM DENIED. 39590 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 39594, 39394, 39399, OR 39391 33983. 3011 CLAIM DENIED. 39590 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 39594, 39396, 0R 39591 33983. 3012 CLAIM DENIED. 39590 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 39594, 39399, OR 393981 33983. 3013 CLAIM DE	5271	
MILEAGE NOT ALLOWED ON THE SAME DATE OF SERVICE AS 20998 5778 GENERAL SERVICES NOT PAYABLE ON SAME DOS AS SPECIAL. 5284 PROCEDURE CODE 12019 AND PROCEDURE CODE 12019, MODIFIER UG, ARE NOT ALLOWED ONTHE SAME DOS, SAME MEMBER. 5295 FROCEDURE CODE 10219 AND PROCEDURE CODE 12019, MODIFIER UG, ARE NOT ALLOWED ONTHE SAME DOS, SAME MEMBER. 5296 FROCEDURE CODES 00170 AND D0220 NOT PAYABLE ON SAME DATE OF SERVICE FOR THESAME MEMBER. 5297 PROCEDURE CODES 00170 AND D0220 NOT PAYABLE ON THE SAME DATE. OF SERVICE FOR THESAME MEMBER. 5298 PROCEDURE CODES 00170 AND D0220 NOT PAYABLE ON SAME DATE. 5309 PROCEDURE CODES 10170 AND TOZO NOT PAYABLE ON SAME DOS. 5300 ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. 5301 SAME MEMBER. 5303 CLAIM DETRIL DENIED. HYSTERECTOMY PROCEDURE CODE SSSSS IS NOT PAYABLE WHEN BILLED IN CONJUNCTION WITH 5304 CLAIM DENIED. 19581 NOT PAYABLE ON SAME DATE OF SERVICE AS 29540 OR 29580. 5305 CLAIM DENIED. 25561 AND TAYABLE ON SAME DATE OF SERVICE AS 29540 OR 29580. 5306 CLAIM DENIED. 32561 AND TAYABLE ON THE SAME DATE OF SERVICE AS 88380 OR 88329-88334. 5307 CLAIM DENIED. 83837 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 88380 OR 88329-88334. 5308 CLAIM DENIED. 83837 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 27192-72194,74150-74170, 74263, 76376, 5309 CLAIM DENIED. 93540 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 27192-72194,74150-74170, 76376, OR 76377. 5310 CLAIM DENIED. 93540 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 27192-72194,74150-74170, 76376, OR 76377. 5311 CLAIM DENIED. 93540 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 29540, 08 29545. 5312 CLAIM DENIED. 93550 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 29590. 5313 CLAIM DENIED. 93500 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 339976, 339976, 339913, 083913, 08331 5314 CLAIM DENIED. 93500 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 339976, 339979, 08 39913, 09334-95936. 5315 CLAIM DENIED. 93500 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 339976, 339979, 0839913, 093934-95936. 531	5272	PROCEDURE CODE NOT ALLOWED FOR DOS AS ADDITIONAL PROCEDURE.
GENERAL SERVICES NOT PAYABLE ON SAME DOS AS SPECIAL. 25284 PROCEDURE CODE H2019 AND PROCEDURE CODE H2019, MODIFIER UG, ARE NOT ALLOWED ONTHE SAME DOS, SAME MEMBER. 25290 SS100 AND SS101 NOT BILLABLE SAME MEMBER SAME DOS 25292 HEMODIALYSIS NOT PAYABLE ON SAME DOS AS EVALUATION PROCEDURE. 2529 PROCEDURE CODES 01070 AND D9230 NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THESAME MEMBER. 2529 PROCEDURE CODES 01070 AND D9230 NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THESAME MEMBER. 2529 PROCEDURE CODES 01070 AND D9230 NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THESAME MEMBER. 2529 PROCEDURE 1025 AND T1026 NOT PAYABLE ON SAME DOS. 25300 ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. 25301 CAID MODIAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. 25302 CLAIM DETAIL DENIED. HYSTERECTOMY PROCEDURE CODE SSSES IS NOT PAYABLE WHEN BILLED IN CONJUNCTION WITH 25303 CLAIM DENIED. 36147 AND 36148 NOT PAYABLE ON SAME DATE OF SERVICE AS 29540 OR 29580. 25304 CLAIM DENIED. 36147 AND 36148 NOT PAYABLE ON SAME DATE OF SERVICE AS 29540 OR 29580. 25305 CLAIM DENIED. 3750 AND TAYABLE ON THE SAME DATE OF SERVICE AS 38380-83314. 25306 CLAIM DENIED. 3750 AND TAYABLE ON THE SAME DATE OF SERVICE AS 38380-83344. 25307 CLAIM DENIED. 3750 AND TAYABLE ON THE SAME DATE OF SERVICE AS 57219-72194,74150-74170, 76376, OR 76377. 25307 CLAIM DENIED. 74263 IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS 57219-72194,74150-74170, 76376, OR 76377. 25301 CLAIM DENIED. 3950 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 37219-72194,74150-74170, 76376, OR 76377. 25301 CLAIM DENIED. 3950 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 7219-72194,74150-74170, 76376, OR 76377. 25301 CLAIM DENIED. 3950 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 7219-72194,74150-74170, 76376, OR 76377. 25301 CLAIM DENIED. 3950 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 7219-72194,74150-74170, 76376, OR 76377. 25301 CLAIM DENIED. 3950 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 33976, 3397	5273	DETAIL DENIED. PROCEDURE CODE IS NOT ALLOWED FOR THE SAME MEMBER, SAME PROVIDER, SAME DATE OF SERVICE AS OTHER
PROCEDURE CODE H2019 AND PROCEDURE CODE H2019, MODIFIER UG, ARE NOT ALLOWED ONTHE SAME DOS, SAME MEMBER A. 2599 S200 AND SSS10 NOT BULLABLE SAME MEMBER SAME DOS 2522 HEMODIALYSIS NOT PAYABLE ON SAME DOS AS EVALUATION PROCEDURE. 2579 PROCEDURE CODES 00170 AND D9220 NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THESAME MEMBER. 2579 PROCEDURE CODES 10170 AND D9220 NOT PAYABLE ON SAME DATE OF SERVICE FOR THESAME MEMBER. 2580 ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. 2590 ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. 2500 ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. 2502 PERIODONTAL SACLING AND ROOT PLAYABLE ON SAME DATE OF SERVICE AS SAME MEMBER, SAME 2503 CLAIM DEFINED. SHYSTER STORM PROCEDURE CODE SSSSS IS NOT PAYABLE WHEN BILLED IN CONJUNCTION WITH 2504 CLAIM DENIED. 36147 AND 36148 NOT PAYABLE ON SAME DATE OF SERVICE AS SAME OR 29580. 2505 CLAIM DENIED. 36147 AND 36148 NOT PAYABLE ON SAME DATE OF SERVICE AS SAME DATE OF SERVICE AS 72192-72194,74150-74170, 74263, 76376, 2506 CLAIM DENIED. 36147 AND 36148 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 83890-83914. 2507 CLAIM DENIED. 838387 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 83890-83914. 2508 CLAIM DENIED. 93250 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 82192-72194,74150-74170, 76376, OR 76377. 2509 CLAIM DENIED. 93250 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 82192-72194,74150-74170, 76376, OR 76377. 2510 CLAIM DENIED. 93250 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 82192-72194,74150-74170, 76376, OR 76377. 2511 CLAIM DENIED. 93250 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92341, 92542, 92544, OR 92545. 2512 CLAIM DENIED. 93250 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92567 OR 92558. 2513 CLAIM DENIED. 93250 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 933976, 33979, OR 33931-33983. 2514 CLAIM DENIED. 93250 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 933976, 33979, OR 33931-33983. 2515 CLAIM DE	5275	MILEAGE NOT ALLOWED ON THE SAME DATE OF SERVICE AS A0998
\$5290 AND \$5101 MOT BILLABLE SAME MEMBER SAME DOS \$292 HEMODIALYSIS NOT PAYABLE ON SAME DOS AS EVALUATION PROCEDURE. \$295 PROCEDURE CODES 50170 AND 50220 MOT PAYABLE ON THE SAME DON THE SAME DATE OF SERVICE FOR THESAME MEMBER. \$297 PROCEDURE CODES 50170 AND 50220 MOT PAYABLE ON SAME DOS. \$300 ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. \$301 CAIM DEVALUE PROCEDURE. HYSTERECTOMY PROCEDURE CODES 3855 IS NOT PAYABLE ON THE SAME DATE OF SERVICE, SAME MEMBER, SAME \$302 CLAIM DETAIL DENIED. HYSTERECTOMY PROCEDURE CODE \$3855 IS NOT PAYABLE WHEN BILLED IN CONJUNCTION WITH \$303 CLAIM DETAIL CENTER. HYSTERECTOMY PROCEDURE CODE \$3856 IS NOT PAYABLE WHEN BILLED IN CONJUNCTION WITH \$304 CLAIM DENIED. 3961 NOT PAYABLE ON SAME DATE OF SERVICE AS 29540 OR 29580. \$305 CLAIM DENIED. 3961 NOT PAYABLE ON SAME DATE OF SERVICE AS 29540 OR 29580. \$306 CLAIM DENIED. 3961 MOT PAYABLE ON THE SAME DATE OF SERVICE AS 3980-83914. \$307 CLAIM DENIED. 87350 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 38890-83914. \$308 CLAIM DENIED. 87350 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 52829-72194,74150-74170, 76376, OR 76377. \$309 CLAIM DENIED. 87350 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 52829-72194,74150-74170, 76376, OR 76377. \$300 CLAIM DENIED. 39550 AND 92570 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 52829-72194,74150-74170,76376, OR 76377. \$301 CLAIM DENIED. 93550 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 5283975, 33979, OR 33981-33983. \$302 CLAIM DENIED. 93550 AND 92570 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 723975, 33979, OR 33981-33983. \$303 CLAIM DENIED. 93550 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 529567 OR 92588. \$304 CLAIM DENIED. 93550 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 53950-35900 OR 93934-55936. \$304 CLAIM DENIED. 93550 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 53975, 33979, OR 33981-33983. \$305 CLAIM DENIED. 93550 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 53955. \$306 CLAIM DENIED. 93550 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 539550-35900 OR 9	5278	GENERAL SERVICES NOT PAYABLE ON SAME DOS AS SPECIAL.
HEMODIALYSIS NOT PAYABLE ON SAME DOS AS EVALUATION PROCEDURE. PROCE CODES TIDES AND TIDES NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THESAME MEMBER. PROC CODES TIDES AND TIDES NOT PAYABLE ON SAME DOS. ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. CLAIM DETRIL DENIED. HYSTERECTOMY PROCEDURE CODE SSESS IS NOT PAYABLE WHEN BILLED IN CONJUNCTION WITH GOVERNOR WITH CONJUNCTION WITH GOVERNOR WIT	5284	PROCEDURE CODE H2019 AND PROCEDURE CODE H2019, MODIFIER UG, ARE NOT ALLOWED ONTHE SAME DOS, SAME MEMBER.
PROCEDURE CODES 00170 AND D3220 NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THESAME MEMBER. PROC CODES T1.025 AND T1.026 NOT PAYABLE ON SAME DOS. ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. PERIODONTAL SACLING AND ROOT PLANNING (D4341) IS NOT ALLOWEDON SAME DATE OF SERVICE, SAME MEMBER, SAME ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. EVENTOR OF THE SAME MEMBER, SAME CLAIM DETAIL DENIED. HYSTERCTORY PROCEDURE CODE SSS65 IS NOT PAYABLE WHEN BILLED IN CONJUNCTION WITH CLAIM DENIED. 36147 AND 36148 NOT PAYABLE ON SAME DATE OF SERVICE AS 29540 OR 29580. CLAIM DENIED. 36147 AND 36148 NOT PAYABLE ON SAME DATE OF SERVICE AS 29540 OR 29580. CLAIM DENIED. 36147 AND 36148 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 29540 OR 88329-88334. CLAIM DENIED. 87150 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 38389 OR 88329-88334. CLAIM DENIED. 87150 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 38389 OR 88329-88334. CLAIM DENIED. 87250 AND PAYABLE ON THE SAME DATE OF SERVICE AS 38389 OR 88329-88334. CLAIM DENIED. 92540 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 29541, 92542, 92544, OR 92545. CLAIM DENIED. 92550 AND 92570 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 29541, 92542, 92544, OR 92545. CLAIM DENIED. 92550 AND 92570 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 33975, 33976, 33979, OR 33981-33983. CLAIM DENIED. 93590 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 93900-93900 OR 99349-39936. CLAIM DENIED. 93590 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 93900-93900 OR 99349-39936. CLAIM DENIED. 93590 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 93900-93900 OR 99349-39936. CLAIM DENIED. 55550 AND 92570 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 93900-93900 OR 99383. CLAIM DENIED. 5550 IS ONLY PAYABLE ON THE SAME DATE OF SERVICE AS 93900-93900 OR 993893. CLAIM DENIED. 5550 IS ONLY PAYABLE ON THE SAME DATE OF SERVICE AS 93900-93900 OR 993893. CLAIM DENIED. 5550 IS ONLY PAYABLE ON THE SAME DATE OF SERVICE AS 939	5290	S5100 AND S5101 NOT BILLABLE SAME MEMBER SAME DOS
PROC CODES 1302S AND T1026 NOT PAYABLE ON SAME DOS. ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. PRICIDONTAL SACLING AND ROOT PLANNING [04341] IS NOT ALLOWEDON SAME DATE OF SERVICE, SAME MEMBER, SAME SAME CLAIM DENIED. HYSTERECTOMY PROCEDURE CODE 58565 IS NOT PAYABLE WHEN BILLED IN CONJUNCTION WITH CLAIM DENIED. 2585 IN OT PAYABLE ON SAME DATE OF SERVICE S. SAME MEMBER, SAME SAME CLAIM DENIED. 36137 AND 36148 NOT PAYABLE ON SAME DATE OF SERVICE S. SERVICE NOT PAYABLE ON SAME DATE OF SERVICE AS 72192-72194,74150-74170, 74263, 76376, CLAIM DENIED. 73215 AND 74262 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 74263, 76376, CLAIM DENIED. 73215 AND 74262 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 88389-88394. CLAIM DENIED. 7325 IN OT PAYABLE ON THE SAME DATE OF SERVICE AS 88389-88394. CLAIM DENIED. 7325 IN OT PAYABLE ON THE SAME DATE OF SERVICE AS 88389 OR 88329-88334. CLAIM DENIED. 7325 IN OT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 76376, OR 76377. CLAIM DENIED. 7325 IN OT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 76376, OR 76377. CLAIM DENIED. 93250 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 76376, OR 76377. CLAIM DENIED. 93250 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 76376, OR 76377. CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 723670, 83981-33981. CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 723670, 83981-33981. CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 93950, 93394-95936. CLAIM DENIED. 93505 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 93950, 9394-95936. CLAIM DENIED. 93505 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 93950, 9394-95936. CLAIM DENIED. 75557, 75559, 75561, 75563, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE. CLAIM DENIED. 75555 IS OBLY PAYABLE ON THE SAME DATE OF SERVICE. CLAIM DENIED. 75555 IS OBLY PAYABLE IN CONJUNCTI	5292	HEMODIALYSIS NOT PAYABLE ON SAME DOS AS EVALUATION PROCEDURE.
ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. PERIODONTAL SACLING AND ROOT PLANNING (D4341) IS NOT ALLOWEDON SAME DATE OF SERVICE, SAME MEMBER, SAME LAIM DETAIL DENIED. HYSTERECTOMY PROCEDURE CODE 58556 IS NOT PAYABLE WHEN BILLED IN CONJUNCTION WITH CLAIM DETRIL DENIED. HYSTERECTOMY PROCEDURE CODE 58556 IS NOT PAYABLE WHEN BILLED IN CONJUNCTION WITH CLAIM DENIED. 31017 AND 36148 NOT PAYABLE ON SAME DATE OF SERVICE AS 29540 OR 29580. CLAIM DENIED. 37147 AND 36148 NOT PAYABLE ON SAME DOATS OF SERVICE AS 29540 OR 29580. CLAIM DENIED. 74261 AND 74262 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 74263, 76376, CLAIM DENIED. 38150 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 88380-083914. CLAIM DENIED. 3818 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 88380 OR 88329-88334. CLAIM DENIED. 74263 IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS 88388 OR 88329-88334. CLAIM DENIED. 74263 IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92540, 29244, 09244, 08 92545. S1310 CLAIM DENIED. 39250 AND 92570 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92540, 29244, 09246, 08 92545. S1311 CLAIM DENIED. 39250 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 93975, 33976, 33979, OR 33981-33983. CLAIM DENIED. 393750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 93905 OR 959394 OR 95934-33983. CLAIM DENIED. 39350 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 395900 S9590 OR 95934-39386. CLAIM DENIED. 39350 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 395900 S9590 OR 95934-39383. CLAIM DENIED. 39350 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 395900 S9590 OR 95934-39383. CLAIM DENIED. 39350 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 395900 S9590 OR 95934-39383. CLAIM DENIED. 39350 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 395900 S9590 OR 95934-393936. CLAIM DENIED. 39350 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 39500 S9590 OR 95934-393936. CLAIM DENIED. 39350 NOT PAYABLE IN CONJUNCTION WITH 56490 (SAME DATE OF SERVICE). CLAIM DENIED. 39350 NOT PAYABLE ON THE SAME DAT	5295	PROCEDURE CODES 00170 AND D9220 NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THESAME MEMBER.
PERIODONTAL SACLING AND ROOT PLANNING (D4241) IS NOT ALLOWEDON SAME DATE OF SERVICE, SAME MEMBER, SAME CLAIM DETAIL DENIED. HYSTERECTOMY PROCEDURE CODE 58565 IS NOT PAYABLE UN CONJUNCTION WITH S303 CLAIM DENIED. 29581 NOT PAYABLE ON SAME DATE OF SERVICE AS 29540 OR 29580. CLAIM DENIED. 36147 AND 36148 NOT PAYABLE ON SAME DOS AS 75791. CLAIM DENIED. 36147 AND 36148 NOT PAYABLE ON SAME DOS AS 75791. CLAIM DENIED. 36147 AND 36148 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 74263, 76376, S305 CLAIM DENIED. 36145 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 83890-83914. S308 CLAIM DENIED. 36146 IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS 83890-83914. S308 CLAIM DENIED. 3628 IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS 82890-83914. S309 CLAIM DENIED. 3628 IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 76376, OR 76377. S310 CLAIM DENIED. 36250 AND 2570 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92541, 92542, 92544, OR 92545. S311 CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 39975, 339976, 339979, OR 339981-33983. CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92567 OR 95934-95936. CLAIM DENIED. 9590S NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92590-95904 OR 95934-95936. CLAIM DENIED. 9590S NOT PAYABLE ON THE SAME DATE OF SERVICE AS 93900-95904 OR 95934-95936. CLAIM DENIED. 9590S NOT PAYABLE ON THE SAME DATE OF SERVICE AS 93900-95904 OR 95934-95936. CLAIM DENIED. 9590S NOT PAYABLE ON THE SAME DATE OF SERVICE AS 93000-95904 OR 95934-95936. CLAIM DENIED. 9590S NOT PAYABLE ON THE SAME DATE OF SERVICE AS 93000-95904 OR 95934-95936. CLAIM DENIED. 75557, 75559, 755561, 75563, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE). S311 CLAIM DENIED. 9590S NOT PAYABLE ON THE SAME DATE OF SERVICE AS 76376 OR 76377. CLAIM DENIED. 75557, 75559, 755561, 75563, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 76376 OR 76377. S312 CLAIM DENIED. 84043 AND 64395 MUST BE BILLED IN CONJUNCTION WITH 84493 (SAME DATE OF SER	5297	PROC CODES T1025 AND T1026 NOT PAYABLE ON SAME DOS.
CLAIM DETAIL DENIED. HYSTERECTOMY PROCEDURE CODE. \$8555.IS NOT PAYABLE WHEN BILLED IN CONJUNCTION WITH CLAIM DENIED. 3951 NOT PAYABLE ON SAME DATE OF SERVICE AS 29540 OR 29580.	5300	ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES.
CLAIM DENIED. 29581 NOT PAYABLE ON SAME DATE OF SERVICE AS 29540 OR 29580.	5302	PERIODONTAL SACLING AND ROOT PLANNING (D4341) IS NOT ALLOWEDON SAME DATE OF SERVICE, SAME MEMBER, SAME
CLAIM DENIED. 36147 AND 36148 NOT PAYABLE ON SAME DOS AS 75791.	5303	CLAIM DETAIL DENIED. HYSTERECTOMY PROCEDURE CODE 58565 IS NOT PAYABLE WHEN BILLED IN CONJUNCTION WITH
CLAIM DENIED. 74261 AND 74262 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 74263, 76376, 15307 CLAIM DENIED. 87150 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 83890-83914. S1008 CLAIM DENIED. 83887 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 83890-83914. S1010 CLAIM DENIED. 74263 IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 76376, OR 76377. S1110 CLAIM DENIED. 92540 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92541, 92542, 92544, OR 92545. S1121 CLAIM DENIED. 92550 AND 92570 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 39375, 33976, 33979, OR 33991-33983. S1312 CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 39375, 33976, 33979, OR 33991-33983. S1313 CLAIM DENIED. 99590 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 39375, 33976, 33979, OR 33991-33983. S1314 CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 39375, 33976, 33979, OR 33991-33983. S1315 CLAIM DENIED. 95950, NOT PAYABLE ON THE SAME DATE OF SERVICE AS 39375, 33976, 33979, OR 33991-33983. S1316 CLAIM DENIED. 64491 AND 64492 MUST BE BILLED IN CONJUNCTION WITH 64490 (SAME DATE OF SERVICE). S1317 CLAIM DENIED. 75557, 75559, 75561, 75563, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 76376 OR 76377. CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 75557, 75559, 75561, OR 75563 (SAME DATE OF SERVICE). S1317 CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 75557, 75559, 75561, OR 75563 (SAME DATE OF SERVICE). S1318 CLAIM DENIED. PROCEDURE CODES A3531 AND A3522 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE SA 54353. S1320 PROCEDURE CODES 99408 AND 99409 NOT ALVOWED ON THE SAME DATE OF SERVICE AS PROCEDURE CODE 99408 AND 99409 NOT ALVOWED ON THE SAME DATE OF SERVICE AS PROCEDURE CODE 99408 AND 99409 NOT ALVOWED ON THE SAME DATE OF SERVICE AS PROCEDURE CODE 99417 MUST BE BILLED IN CONJUNCTION WITH PROCEDURE CODE 155 OR 159. S1321 PROCEDURE CODE 99408 AND 99409 NOT ALVOWED ON THE SAME DATE OF SERVICE AS	5304	CLAIM DENIED. 29581 NOT PAYABLE ON SAME DATE OF SERVICE AS 29540 OR 29580.
CLAIM DENIED. 87150 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 83890-83914. 15308 CLAIM DENIED. 74263 IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS 83838 OR 88329-88334. 15310 CLAIM DENIED. 74263 IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS 83838 OR 88329-88334. 15311 CLAIM DENIED. 92540 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92541, 92542, 92544, 0R 92545. 15312 CLAIM DENIED. 92550 AND 92570 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92541, 92542, 92544, 0R 92545. 15312 CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 33975, 33976, 33979, OR 33981-33938. 15313 CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 93900-95904 OR 95934-95936. 15314 CLAIM DENIED. 95905 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 95900-95904 OR 95934-95936. 15315 CLAIM DENIED. 64491 AND 64492 MUST BE BILLED IN CONJUNCTION WITH 64490 (SAME DATE OF SERVICE). 15316 CLAIM DENIED. 75557, 75559, 75561, 75563, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE, 15317 CLAIM DENIED. 64494 AND 64495 MUST BE BILLED IN CONJUNCTION WITH 64493 (SAME DATE OF SERVICE). 15318 CLAIM DENIED. 64494 AND 64495 MUST BE BILLED IN CONJUNCTION WITH 64493 (SAME DATE OF SERVICE). 15319 CLAIM DENIED. 75557, 75559, 75561, 75563, AND 7565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE). 15310 CLAIM DENIED. 75557 (SAME DATE OF SERVICE). 15311 CLAIM DENIED. 83388 IS ONLY PAYABLE IN CONJUNCTION WITH 75557, 75559, 75561, OR 75563 (SAME DATE OF SERVICE). 15312 CLAIM DENIED. 83388 IS ONLY PAYABLE IN CONJUNCTION WITH 83292 THROUGH 88334 (SAME DATE OF SERVICE). 15313 CLAIM DENIED. PROCEDURE CODES A3351 AND A3352 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS PROCEDURE CODE 99408 AND 99409 NOT ALLOWED ON THE SAME DATE OF SERVICE. 15322 PROCEDURE CODE 99408 AND 99409 NOT ALLOWED ON THE SAME DATE OF SERVICE AS PROCEDURE CODE 99210. ON THE SAME DATE OF SERVICE AS PROCEDURE CODE 99213. 15323 REVENUE CODE SOS DAUST BE BILLED IN CONJUNCTION WITH 99205, 99215, 99345, 99345, 99350 OR 99483. 15324 PROCEDURE CODE 99408 AND 99409 NO	5305	CLAIM DENIED. 36147 AND 36148 NOT PAYABLE ON SAME DOS AS 75791.
CLAIM DENIED. 88387 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 88388 OR 88329-88334. CLAIM DENIED. 74263 IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 76376, OR 76377. CLAIM DENIED. 92540 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 76376, OR 76377. CLAIM DENIED. 92550 AND 92570 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92541, 92542, 92544, 08 92545. CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 39253, 33376, 33970, OR 33981-33983. CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 39373, 33976, 33979, OR 33981-33983. CLAIM DENIED. 95950 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 39309-39904 995934. CLAIM DENIED. 95950 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 39309-95904 OR 95934-95936. CLAIM DENIED. 95950, NOT PAYABLE ON THE SAME DATE OF SERVICE AS 93909-95904 OR 95934-95936. CLAIM DENIED. 95557, 75559, 75561, 75563, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 76376 OR 76377. CLAIM DENIED. 44094 AND 64493 MUST BE BILLED IN CONJUNCTION WITH 64490 (SAME DATE OF SERVICE AS 76376 OR 76377. CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 75557, 75559, 75561, OR 75563 (SAME DATE OF SERVICE). CLAIM DENIED. 95567, 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 83232 THROUGH 88334 (SAME DATE OF SERVICE). CLAIM DENIED. PROCEDURE CODES 43351 AND A3352 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE SERVICE AS A3353. CLAIM DENIED. PROCEDURE CODES 43351 AND A3352 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE. PROCEDURE CODE 599408 AND 99409 NOT PAYABLE ON SAME DATE OF SERVICE AS PROCEDURE CODE 99213. PROCEDURE CODE 599408 AND 99409 NOT PAYABLE ON THE SAME DATE OF SERVICE. PROCEDURE CODE 599408 AND 99409 NOT PAYABLE ON THE SAME DATE OF SERVICE. PROCEDURE CODE 599408 AND 99409 NOT PAYABLE ON THE SAME DATE OF SERVICE. PROCEDURE CODE 599408 AND 99409 NOT PAYABLE ON THE SAME DATE OF SERVICE. PROCEDURE CODE 599408 AND 599409 NOT PAYABLE ON THE SAME DATE OF SERVICE AS PROCEDURE CODE 599408. PROCEDURE CODE 599417 MUST	5306	CLAIM DENIED. 74261 AND 74262 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 74263, 76376,
CLAIM DENIED. 74263 IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 76376, OR 76377. CLAIM DENIED. 92540 AND 92550 AND 92540 DATE OF SERVICE AS 92541, 92542, OR 92545. CLAIM DENIED. 92550 AND 92570 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92567 OR 92568. CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92567 OR 92568. CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 33975, 33976, 33979, OR 33981-33983. CLAIM DENIED. 95905 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 95900-95904 OR 95934-95936. CLAIM DENIED. 95905 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 95900-95904 OR 95934-95936. CLAIM DENIED. 95905 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 95900-95904 OR 95934-95936. CLAIM DENIED. 64491 AND 64492 MUST BE BILLED IN CONJUNCTION WITH 64490 (SAME DATE OF SERVICE). CLAIM DENIED. 75557, 75559, 75561, 75563, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 76376 OR 76377. CLAIM DENIED. 84494 AND 64495 MUST BE BILLED IN CONJUNCTION WITH 64493 (SAME DATE OF SERVICE). CLAIM DENIED. 84494 AND 64495 MUST BE BILLED IN CONJUNCTION WITH 64493 (SAME DATE OF SERVICE). CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 75557, 75559, 75561, OR 75563 (SAME DATE OF SERVICE). CLAIM DENIED. PROCEDURE CODES 4351 AND A352 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS A4353. CLAIM DENIED. PROCEDURE CODES 99409 NOT PAYABLE ON SAME DATE OF SERVICE AS PROCEDURE CODE 99213. PROCEDURE CODE 99408 AND 99409 NOT PAYABLE ON SAME DATE OF SERVICE AS PROCEDURE CODE 99210 NOTHE SAME DATE OF SERVICE. CLAIM DENIED. PROCEDURE CODE SOON THE SAME DATE OF SERVICE. CRAIM PROCEDURE CODE 99408 AND 99409 NOT PAYABLE ON SAME DATE OF SERVICE. CRAIM PROCEDURE CODE 99408 AND 99409 NOT PAYABLE ON THE SAME DATE OF SERVICE. CRAIM PROCEDURE CODE 99409 NOT PAYABLE ONLY WHEN BILLED IN CONJUNCTION WITH PROCEDURE CODE 99210 NOTHE SAME DATE OF SERVICE. CRAIM PROCEDURE CODE 99408 AND 99409 NOT PAYABLE ON THE SAME DATE OF SERVICE. CRAIM PROCEDURE CODE 99410 MUST BE BILLED IN CONJU	5307	CLAIM DENIED. 87150 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 83890-83914.
CLAIM DENIED. 92540 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92541, 92542, 92544, OR 92545. CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92567 OR 92568. CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92567 OR 92568. CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 93970, 33979, OR 33981-33983. CLAIM DENIED. 95905 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 95900-95904 OR 95934-95936. CLAIM DENIED. 64491 AND 64492 MUST BE BILLED IN CONJUNCTION WITH 64490 (SAME DATE OF SERVICE AS 76376 OR 76377. CLAIM DENIED. 55547, 75559, 75561, 75563, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 76376 OR 76377. CLAIM DENIED. 55547, 75599, 75561, 35636, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE). CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 75557, 75599, 75561, OR 75563 (SAME DATE OF SERVICE). CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 8329 THROUGH 88334 (SAME DATE OF SERVICE). CLAIM DENIED. PROCEDURE CODES A3351 AND A4352 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS A4353. PROCEDURE CODES 99408 AND 99409 NOT PAYABLE ON SAME DATE OF SERVICE AS PROCEDURE CODE 99213. PROCEDURE CODE 99408 AND 99409 NOT PAYABLE ON SAME DATE OF SERVICE AS PROCEDURE CODE 99210. PROCEDURE CODE 60390 IS PAYABLE ONLY WHEN BILLED IN CONJUNCTION WITH PROCEDURECODE 99291 ON THE SAME DATE OF SERVICE. CRAIM PROCEDURE CODE 50390 IS PAYABLE ONLY WHEN BILLED IN CONJUNCTION WITH PROCEDURE CODE 99210 N THE SAME DATE OF SERVICE. PROCEDURE CODE 99417 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. CRAIM PROCEDURE CODE 99417 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. CRAIM PROCEDURE CODE 99417 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 150 OR 159. CRAIM PROCEDURE CODE 99417 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 16061 IS PAID IN HISTORY FOR THE SAME BASE OF PROCEDURE CODE 60601 IS PAID IN HISTORY FOR THE SAME BASE OF PROCEDURE CODE 6061 IS PAID IN HISTORY FOR THE SAME BASE OF PROCEDURE CODE 6061 IS PAID IN HIS	5308	CLAIM DENIED. 88387 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 88388 OR 88329-88334.
CLAIM DENIED. 92550 AND 92570 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92567 OR 92568. CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 33975, 33976, 33979, 08 33981-33983. CLAIM DENIED. 95905 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 95900-95904 OR 95934-95936. CLAIM DENIED. 95905 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 95900-95904 OR 95934-95936. CLAIM DENIED. 64491 AND 64492 MUST BE BILLED IN CONJUNCTION WITH 64490 (SAME DATE OF SERVICE). CLAIM DENIED. 75557, 75559, 75563, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 76376 OR 76377. CLAIM DENIED. 75557, 75559, 75563, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE. CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 64493 (SAME DATE OF SERVICE). CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 75557, 75559, 75561, OR 75563 (SAME DATE OF SERVICE). CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 88329 THROUGH 88334 (SAME DATE OF SERVICE). CLAIM DENIED. PROCEDURE CODES 49436 AND 94352 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS A4353. CLAIM DENIED. PROCEDURE CODES 94436 AND 9409 NOT ALLOWED ON THE SAME DATE OF SERVICE AS PROCEDURE CODE 99408 AND 99409 NOT ALLOWED ON THE SAME DATE OF SERVICE. PROCEDURE CODE 93408 AND 9409 NOT ALLOWED ON THE SAME DATE OF SERVICE. REVENUE CODE 509 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. REVENUE CODE 509 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. REVENUE CODE 509 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. REVENUE CODE 509 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. REVENUE CODE 509 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. REVENUE CODE 509 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. REVENUE CODE 509 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. REVENUE CODE 509 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. REVENUE CODE 509 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. REVENUE CODE 509 MUST BE 500 ALLOWED	5309	CLAIM DENIED. 74263 IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 76376, OR 76377.
CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 33975, 33976, 33979, OR 33981-33983. CLAIM DENIED. 95905 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 95900-95904 OR 95934-95936. CLAIM DENIED. 64491 AND 64492 MUST BE BILLED IN CONJUNCTION WITH 64490 (SAME DATE OF SERVICE). CLAIM DENIED. 75557, 75559, 75561, 75563, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 76376 OR 76377. CLAIM DENIED. 64494 AND 64495 MUST BE BILLED IN CONJUNCTION WITH 64493 (SAME DATE OF SERVICE). CLAIM DENIED. 64494 AND 64495 MUST BE BILLED IN CONJUNCTION WITH 64493 (SAME DATE OF SERVICE). CLAIM DENIED. 64494 AND 64495 MUST BE BILLED IN CONJUNCTION WITH 64493 (SAME DATE OF SERVICE). CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 75557, 75559, 75561, OR 75563 (SAME DATE OF SERVICE). CLAIM DENIED. 78565 IS ONLY PAYABLE IN CONJUNCTION WITH 75577, 75559, 75561, OR 75563 (SAME DATE OF SERVICE). CLAIM DENIED. 78062 PAYABLE IN CONJUNCTION WITH 8329 THROUGH 88334 (SAME DATE OF SERVICE). CLAIM DENIED. PROCEDURE CODES 943631 AND A4352 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS PROCEDURE CODE 99408 AND 99409 NOT PAYABLE ON SAME DATE OF SERVICE AS PROCEDURE CODE 99213. PROCEDURE CODE 99408 AND 99409 NOT PAYABLE ON SAME DATE OF SERVICE. PROCEDURE CODE 99408 AND 99409 NOT ALLOWED ON THE SAME DATE OF SERVICE. S222 PROCEDURE CODE GO390 IS PAYABLE ONLY WHEN BILLED IN CONJUNCTION WITH PROCEDURECODE 99210 ON THE SAME DATE OF SERVICE. CRAIM SERVICE ONLY ONLY BE BILLED IN CONJUNCTION WITH PROCEDURE ONLY SERVICE. CRAIM SERVICE ONLY SERVICE. CRAIM SERVICE ONLY SERVICE. CRAIM SERVICE. C	5310	CLAIM DENIED. 92540 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92541, 92542, 92544, OR 92545.
CLAIM DENIED. 95905 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 95900-95904 OR 95934-95936. CLAIM DENIED. 64491 AND 64492 MUST BE BILLED IN CONJUNCTION WITH 64490 (SAME DATE OF SERVICE). CLAIM DENIED. 75557, 75559, 75561, 75563, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 76376 OR 76377. CLAIM DENIED. 64494 AND 64495 MUST BE BILLED IN CONJUNCTION WITH 64493 (SAME DATE OF SERVICE AS 76376 OR 76377. CLAIM DENIED. 64494 AND 64495 MUST BE BILLED IN CONJUNCTION WITH 64493 (SAME DATE OF SERVICE). S317 CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 75557, 75559, 75561, OR 75563 (SAME DATE OF SERVICE). S318 CLAIM DENIED. PROCEDURE CODES A4351 AND A4352 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE. S319 CLAIM DENIED. PROCEDURE CODES A4351 AND A4352 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 84353. S320 PROCEDURE CODES 99408 AND 99409 NOT PAYABLE ON SAME DATE OF SERVICE AS PROCEDURE CODE 99213. S321 PROCEDURE CODE 99408 AND 99409 NOT ALLOWED ON THE SAME DATE OF SERVICE. S322 PROCEDURE CODE 99408 AND 99409 NOT ALLOWED ON THE SAME DATE OF SERVICE. PROCEDURE CODE 590 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. S324 PROCEDURE CODE 590408 AND 99409 NOT ALLOWED ON THE SAME DATE OF SERVICE. S325 CCBHC CLAIMS REQUIRE TIQUE TO CONJUNCTION WITH REVENUE CODE 155 OR 159. S326 REVENUE CODE 590 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. S327 V5171, V5172, AND V5181 ONLY PAYABLE IF DATE OF SERVICE IS WITHIN 5 YEARS OF CERTAIN PREVIOUSLY PAID HEARING AID S328 RENTAL OF PROCEDURE CODE E0560 ALLOWED ONLY IF PRIVACH OF PROCEDURE CODE E0601 IS PAID IN HISTORY FOR THE SAME S329 PROCEDURE CODE E0560 AND E0562 NOT ALLOWED IN THE SAME MONTH. S330 THE PREOPERATIVE AND/OR POSTOPERATIVE MANAGEMENT CARE HAS ALREADY BEEN PAID TO ANOTHER PROVIDER. S331 DETAIL DENIED. PROCEDURE CODE HAS BEEN PAID IN FULL OR PARTIALLY PAID TO ANOTHER PROVIDER. S331 DETAIL DENIED. PROCEDURE CODE HAS BEEN PAID IN FULL OR PARTIALLY PAID TO ANOTHER PROVIDER. S331 DETAIL DENIED. PROCEDURE CODE HAS	5311	CLAIM DENIED. 92550 AND 92570 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92567 OR 92568.
CLAIM DENIED. 64491 AND 64492 MUST BE BILLED IN CONJUNCTION WITH 64490 (SAME DATE OF SERVICE). CLAIM DENIED. 75557, 75559, 75561, 75563, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 76376 OR 76377. CLAIM DENIED. 64494 AND 64495 MUST BE BILLED IN CONJUNCTION WITH 64493 (SAME DATE OF SERVICE). CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 75557, 75559, 75561, OR 75563 (SAME DATE OF SERVICE). CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 75557, 75559, 75561, OR 75563 (SAME DATE OF SERVICE). CLAIM DENIED. 88388 IS ONLY PAYABLE IN CONJUNCTION WITH 88329 THROUGH 88334 (SAME DATE OF SERVICE). CLAIM DENIED. PROCEDURE CODES A4351 AND A4352 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS A4353. PROCEDURE CODES 99408 AND 99409 NOT PAYABLE ON SAME DATE OF SERVICE AS PROCEDURE CODE 99213. PROCEDURE CODE 99408 AND 99409 NOT PAYABLE ON SAME DATE OF SERVICE AS PROCEDURE CODE 99213. PROCEDURE CODE 99408 AND 99409 NOT ALLOWED ON THE SAME DATE OF SERVICE. PROCEDURE CODE 599408 AND 99409 NOT ALLOWED ON THE SAME DATE OF SERVICE. PROCEDURE CODE 509417 MUST BE BILLED IN CONJUNCTION WITH PROCEDURECODE 99291 ON THE SAME DATE OF SERVICE. PROCEDURE CODE 99417 MUST BE BILLED IN CONJUNCTION WITH 99205, 99215, 99245, 99345, 99350 OR 99483. CEBHC CLAIMS REQUIRE T1040 PLUS AT LEAST ONE OTHER COVERED SERVICE. CEBHC CLAIMS REQUIRE T1040 PLUS AT LEAST ONE OTHER COVERED SERVICE. WITH THE SAME MONTH OF PROCEDURE CODE E0560 ALLOWED ONLY IF PRENTAL OF PROCEDURE CODE E0601 IS PAID IN HISTORY FOR THE SAME PURCHASE OF PROCEDURE CODE E0601 IS PAID IN HISTORY FOR SAME PURCHASE OF PROCEDURE CODE E0601 IS PAID IN HESTORY FOR SAME PURCHASE OF PROCEDURE CODE E0560 ALLOWED ONLY IF PURCHASE OF PROCEDURE CODE E0601 IS PAID IN HISTORY FOR SAME PURCHASE OF PROCEDURE CODE E0560 AND E0562 NOT ALLOWED IN THE SAME MONTH. S330 THE PREOPERATIVE AND/OR POSTOPERATIVE MANAGEMENT CARE HAS ALREADY BEEN PAID TO ANOTHER PROVIDER. S331 DETAIL DENIED. PROCEDURE CODE E0560 AND E0562 NOT ALLOWED IN THE SAME MONTH. S441 PROCEDURE CO	5312	CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 33975, 33976, 33979, OR 33981-33983.
CLAIM DENIED. 75557, 75559, 75561, 75563, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 76376 OR 76377. CLAIM DENIED. 64494 AND 64495 MUST BE BILLED IN CONJUNCTION WITH 64493 (SAME DATE OF SERVICE). CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 75557, 75559, 75561, OR 75563 (SAME DATE OF SERVICE). CLAIM DENIED. 88388 IS ONLY PAYABLE IN CONJUNCTION WITH 88329 THROUGH 88334 (SAME DATE OF SERVICE). CLAIM DENIED. PROCEDURE CODES 44351 AND A4352 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS A4353. PROCEDURE CODES 99408 AND 99409 NOT PAYABLE ON SAME DATE OF SERVICE AS PROCEDURE CODE 99213. PROCEDURE CODE 69408 AND 99409 NOT ALLOWED ON THE SAME DATE OF SERVICE. PROCEDURE CODE 69303 IS PAYABLE ONLY WHEN BILLED IN CONJUNCTION WITH PROCEDURE CODE 9921 ON THE SAME DATE OF SERVICE. PROCEDURE CODE 69391 SPAYABLE ONLY WHEN BILLED IN CONJUNCTION WITH PROCEDURECODE 99291 ON THE SAME DATE OF SERVICE. PROCEDURE CODE 99417 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. CEBHC CLAIMS REQUIRE T1040 PLUS AT LEAST ONE OTHER COVERED SERVICE. CEBHC CLAIMS REQUIRE T1040 PLUS AT LEAST ONE OTHER COVERED SERVICE. CEBHC CLAIMS REQUIRE T1040 PLUS AT LEAST ONE OTHER COVERED SERVICE. S226 RENTAL OF PROCEDURE CODE 60560 ALLOWED ONLY IF RENTAL OF PROCEDURE CODE 60601 IS PAID IN HISTORY FOR THE SAME 5327 V5171, V5172, AND V5181 ONLY PAYABLE IF DATE OF SERVICE IS WITHIN 5 YEARS OF CERTAIN PREVIOUSLY PAID HEARING AID 5328 PURCHASE OF PROCEDURE CODE 60560 ALLOWED ONLY IF PURCHASE OF PROCEDURE CODE 60601 IS PAID IN HISTORY FOR SAME 5329 RENTAL OF PROCEDURE CODE 60560 ALLOWED ONLY IF PURCHASE OF PROCEDURE CODE 60601 IS PAID IN HISTORY FOR SAME 5329 RENTAL OF PROCEDURE CODE 60560 AND 60562 NOT ALLOWED IN THE SAME MONTH. S330 THE PREOPERATIVE AND/OR POSTOPERATIVE MANAGEMENT NOT ALLOWED IN THE SAME MONTH. S331 DETAIL DENIED. PROCEDURE CODE HAS BEEN PAID IN FULL OR PARTIALLY PAID TO ANOTHER PROVIDER. S332 PROPERATIVE OR POSTOPERATIVE MANAGEMENT NOT ALLOWED IN THE SAME MONTH. S333 CLAIM/DETAIL DENIED. PROC	5313	CLAIM DENIED. 95905 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 95900-95904 OR 95934-95936.
CLAIM DENIED. 64494 AND 64495 MUST BE BILLED IN CONJUNCTION WITH 64493 (SAME DATE OF SERVICE). S317 CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 75557, 75559, 75561, OR 75563 (SAME DATE OF SERVICE). S318 CLAIM DENIED. 88388 IS ONLY PAYABLE IN CONJUNCTION WITH 88329 THROUGH 88334 (SAME DATE OF SERVICE). S319 CLAIM DENIED. PROCEDURE CODES A351 AND A4352 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS A4353. S320 PROCEDURE CODES 99408 AND 99409 NOT PAYABLE ON SAME DATE OF SERVICE AS PROCEDURE CODE 99213. S321 PROCEDURE CODE 99408 AND 99409 NOT PAYABLE ON SAME DATE OF SERVICE. S322 PROCEDURE CODE 60390 IS PAYABLE ONLY WHEN BILLED IN CONJUNCTION WITH PROCEDURECODE 99291 ON THE SAME DATE OF SERVICE. S323 REVENUE CODE 550 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. S324 PROCEDURE CODE 99417 MUST BE BILLED IN CONJUNCTION WITH P90205, 99215, 99245, 99345, 99350 OR 99483. S325 CCBHC CLAIMS REQUIRE T1040 PLUS AT LEAST ONE OTHER COVERED SERVICE. S326 RENTAL OF PROCEDURE CODE E0560 ALLOWED ONLY IF RENTAL OF PROCEDURE CODE E0601 IS PAID IN HISTORY FOR THE SAME DATE OF SERVICE IS WITHIN S YEARS OF CERTAIN PREVIOUSLY PAID HEARING AID S328 PURCHASE OF PROCEDURE CODE E0560 ALLOWED ONLY IF PURCHASE OF PROCEDURE CODE E0601 IS PAID IN HISTORY FOR SAME PURCHASE OF PROCEDURE CODE E0560 AND E0562 NOT ALLOWED IN THE SAME MONTH. S330 THE PREOPERATIVE AND/OR POSTOPERATIVE MANAGEMENT CARE HAS ALREADY BEEN PAID TO ANOTHER PROVIDER. S331 DETAIL DENIED. PROCEDURE CODE HAS BEEN PAID IN FULL OR PARTIALLY PAID TO ANOTHER SURGEON. PROPERATIVE OR POSTOPERATIVE MANAGEMENT NOT ALLOWED IF SURGICAL CARE HAS NOT BEEN PAID IN HISTORY. S331 CLAIM/DETAIL DENIED. PROCEDURE CODE 99417 IS NOT PAYABLE WHEN BILLED IN CONJUCTION WITH MONITORED PROCEDURE MILEAGE, OXYGEN AND SUPPLIES PROC CODE MUST MATCH. FLUORIDE MUST BE BILLED IN CONJUNCTION WITH PROCEDURE CODE 58565. S421 99292 MUST BE BILLED WIND NOT SELLED WITH PROCEDURE CODE 58565. S422 PERI AND ROOT SCALING NOT ALLOWED SOOS AS PROPHY S428 PROCEDURE CODE 90785	5314	CLAIM DENIED. 64491 AND 64492 MUST BE BILLED IN CONJUNCTION WITH 64490 (SAME DATE OF SERVICE).
CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 75557, 75559, 75561, OR 75563 (SAME DATE OF SERVICE). S318 CLAIM DENIED. 88388 IS ONLY PAYABLE IN CONJUNCTION WITH 88329 THROUGH 88334 (SAME DATE OF SERVICE). S319 CLAIM DENIED. PROCEDURE CODES 44351 AND 44352 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS A4353. S320 PROCEDURE CODES 99408 AND 99409 NOT PAYABLE ON SAME DATE OF SERVICE AS PROCEDURE CODE 99213. S321 PROCEDURE CODE 99408 AND 99409 NOT ALLOWED ON THE SAME DATE OF SERVICE. S322 PROCEDURE CODE 60390 IS PAYABLE ONLY WHEN BILLED IN CONJUNCTION WITH PROCEDURECODE 99291 ON THE SAME DATE OF SERVICE. S322 PROCEDURE CODE 60390 IS PAYABLE ONLY WHEN BILLED IN CONJUNCTION WITH PROCEDURECODE 99291 ON THE SAME DATE OF SERVICE. S324 PROCEDURE CODE 99417 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. S325 CCBHC CLAIMS REQUIRE T1040 PLUS AT LEAST ONE OTHER COVERED SERVICE. S326 RENTAL OF PROCEDURE CODE 60560 ALLOWED ONLY IF RENTAL OF PROCEDURE CODE 60601 IS PAID IN HISTORY FOR THE SAME S327 V5171, V5172, AND V5181 ONLY PAYABLE IF DATE OF SERVICE IS WITHIN 5 YEARS OF CERTAIN PREVIOUSLY PAID HEARING AID S328 PURCHASE OF PROCEDURE CODE 60560 ALLOWED ONLY IF PURCHASE OF PROCEDURE CODE 60601 IS PAID IN HISTORY FOR SAME S329 RENTAL OF PROCEDURE CODE 60560 AND 60562 NOT ALLOWED IN THE SAME MONTH. S330 THE PREOPERATIVE AND/OR POSTOPERATIVE MANAGEMENT CARE HAS ALREADY BEEN PAID TO ANOTHER PROVIDER. S331 DETAIL DENIED. PROCEDURE CODE HAS BEEN PAID IN FULL OR PARTIALLY PAID TO ANOTHER SURGEON. S332 PREOPERATIVE OR POSTOPERATIVE MANAGEMENT NOT ALLOWED IF SURGICAL CARE HAS NOT BEEN PAID IN HISTORY. S333 CLAIM/DETAIL DENIED. PROCEDURE CODE HAS BEEN PAID IN FULL OR PAYABLE WHEN BILLED IN CONJUCTION WITH MONITORED PROCEDURE S440 MILEAGE, OXYGEN AND SUPPLIES PROC CODE MUST MATCH. 5417 FLUORIDE MUST BE BILLED IN CONJUNCTION WITH PROCEDURE CODE 58565. 5421 99292 MUST BE BILLED IN CONJUNCTION WITH PROCEDURE CODE 58565. 5424 PROCEDURE CODE 90785 MUST BE BILLED WITH PROCEDURE CODE 58082, 90834 OR 90	5315	CLAIM DENIED. 75557, 75559, 75561, 75563, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 76376 OR 76377.
CLAIM DENIED. 88388 IS ONLY PAYABLE IN CONJUNCTION WITH 88329 THROUGH 88334 (SAME DATE OF SERVICE). CLAIM DENIED. PROCEDURE CODES A4351 AND A4352 ARE NOT PAYABLE ON THE SAME DATEO F SERVICE AS A4353. PROCEDURE CODES 99408 AND 99409 NOT PAYABLE ON SAME DATE OF SERVICE AS PROCEDURE CODE 99213. PROCEDURE CODE 99408 AND 99409 NOT ALLOWED ON THE SAME DATE OF SERVICE. PROCEDURE CODE 99408 AND 99409 NOT ALLOWED ON THE SAME DATE OF SERVICE. PROCEDURE CODE 99408 AND 99409 NOT ALLOWED ON THE SAME DATE OF SERVICE. PROCEDURE CODE 99309 IS PAYABLE ONLY WHEN BILLED IN CONJUNCTION WITH PROCEDURECODE 99291 ON THE SAME DATE OF SERVICE. PROCEDURE CODE 99417 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. PROCEDURE CODE 99417 MUST BE BILLED IN CONJUNCTION WITH 99205, 99215, 99245, 99345, 99350 OR 99483. CCBHC CLAIMS REQUIRE 11040 PLUS AT LEAST ONE OTHER COVERED SERVICE. RENTAL OF PROCEDURE CODE E0560 ALLOWED ONLY IF RENTAL OF PROCEDURE CODE E0601 IS PAID IN HISTORY FOR THE SAME V5171, V5172, AND V5181 ONLY PAYABLE IF DATE OF SERVICE IS WITHIN 5 YEARS OF CERTAIN PREVIOUSLY PAID HEARING AID PURCHASE OF PROCEDURE CODE E0560 ALLOWED ONLY IF PURCHASE OF PROCEDURE CODE E0601 IS PAID IN HISTORY FOR SAME PURCHASE OF PROCEDURE CODE E0560 AND E0562 NOT ALLOWED IN THE SAME MONTH. THE PREOPERATIVE AND/OR POSTOPERATIVE MANAGEMENT CARE HAS ALREADY BEEN PAID TO ANOTHER PROVIDER. DETAIL DENIED. PROCEDURE CODE HAS BEEN PAID IN FULL OR PARTIALLY PAID TO ANOTHER SURGEON. PREOPERATIVE OR POSTOPERATIVE MANAGEMENT NOT ALLOWED IF SURGICAL CARE HAS NOT BEEN PAID IN HISTORY. CLAIM/DETAIL DENIED. PROCEDURE CODE 99417 IS NOT PAYABLE WHEN BILLED IN CONJUCTION WITH MONITORED PROCEDURE MILEAGE, DXYGEN AND SUPPLIES PROC CODE MUST MATCH. FLUORIDE MUST BE BILLED IN CONJUSTION WITH PROPHY FLUORIDE MUST BE BILLED IN CONJUSTION WITH PROPHY SHAPP PROCEDURE CODE 90785 MUST BE BILLED WITH PROCEDURE CODE 58565. PROCEDURE CODE MUST BE BILLED WITH PROCEDURE CODE 58559. PROCEDURE CODE 90785 MUST BE BILLED WITH PROCEDURE CODE 58084 OR 90837.	5316	CLAIM DENIED. 64494 AND 64495 MUST BE BILLED IN CONJUNCTION WITH 64493 (SAME DATE OF SERVICE).
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CLAIM/DETAIL DENIED. THIS NCCI COLUMN 1 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO A PREVIOUSIX PAID CLAIM/DETAIL DENIED. THIS NCCI COLUMN 2 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO A PREVIOUSIX PAID CLAIM/DETAIL DENIED. THIS NCCI COLUMN 1 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO A PREVIOUSIX PAID CLAIM/DETAIL DENIED. THIS NCCI COLUMN 2 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO AN NCCI COLUMN 1 CLAIM/DETAIL DENIED. THIS NCCI COLUMN 2 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO AN NCCI COLUMN 1 CLAIM/DETAIL DENIED. THIS NCCI COLUMN 2 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO AN NCCI COLUMN 1 CLAIM/DETAIL DENIED. THIS NCCI COLUMN 2 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO AN NCCI COLUMN 1 CLAIM/DETAIL DENIED. SPACE SONCE SET DETAIL EXCEEDED. CLAIM/DETAIL DENIED. 99407 IS LIMITED TO 2 UNITS PER CALENDAR YEAR. CEDITOR OF THE COLUMN 2 SHAPP COLUMN 2 SHAPP COLUMN 2 SHAPP COLUMN 2 SHAPP CALENDAR YEAR. CEDITOR OF THE COLUMN 2 SHAPP COLUMN 2 SHAPP CALENDAR YEAR. CEDITOR OF THE COLUMN 2 SHAPP COLUMN 2 SHAPP CALENDAR YEAR. CEDITOR OF THE COLUMN 2 SHAPP COLUMN 2 SHAPP CALENDAR YEAR. CEDITOR OF THE COLUMN 2 SHAPP COLUMN 2 SHAPP CALENDAR YEAR. CEDITOR OF THE COLUMN 2 SHAPP COLUMN 2 SHAPP CALENDAR YEAR. CEDITOR OF THE COLUMN 2 SHAPP COLUMN 2 SHAPP CALENDAR YEAR. CEDITOR OF THE COLUMN 2 SHAPP COLUMN 2 SHAPP CALENDAR YEAR. CEDITOR OF THE COLUMN 2 SHAPP COLUMN 2 SHAPP CALENDAR YEAR. CEDITOR OF THE COLUMN 2 SHAPP CALENDAR YEAR. CEDITOR OF THE CALENDAR YEAR PERFONDER. CETAIN MICHELEP P. WAIVER SERVICES ARE LIMITED TO ONE IN A 90 DAY TIME PERIOD. CERTAIN MICHELEP P. WAIVER SERVICES ARE LIMITED TO ONE IN A 91 DAY TIME PERIOD. CETAIN MICHELEP P. WAIVER SERVICES ARE LIMITED TO SHAPP CALENDAR MONTH. CETAIN COLUMN 2 SHAPP CALENDAR YEAR. CEDITOR OF THE COLUMN 2 SHAPP CALENDAR YE	5607	DETAIL DENIED. PROCEDURE CODE PAID TO ANOTHER PROVIDER FOR THE SAME DATE OF SERVICE.
CLAIM/DETAIL DENIED. THIS NICCI COLLUMN 1 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO AN NICCI COLLUMN 1 5702 CLAIM/DETAIL DENIED. THIS NICCI COLLUMN 1 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO A PREVIOUSLY PAID 5703 CLAIM/DETAIL DENIED. THIS NICCI COLLUMN 2 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO AN NICCI COLLUMN 1 5695 CLAIM/DETAIL DENIED. THIS NICCI COLLUMN 2 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO AN NICCI COLLUMN 1 5695 LIMITATION OF 26 VISITS PER CALENDAR YEAR EXCEEDED. 5699 CLAIM/DETAIL DENIED. 99407 IS LIMITED TO 2 UNITS PER CALENDAR YEAR, PER MEMBER. 5600 MEMBERS ARE LIMITED TO ONE (1) OPTHAMOLOGICAL EXAMINATION PER PROVIDER PER CALENDAR YEAR. 5620 MEMBERS ARE LIMITED TO ONE (1) OPTHAMOLOGICAL EXAMINATION PER PROVIDER, PER CALENDAR YEAR. 5620 STABLISHED PATIENT MEDICAL SERVICES LIMITED TO TWO PER MEMBER PER PROVIDER, PER CALENDAR YEAR. 5621 PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR. REIMBURSEMENT CUT BACK TO RATE FOR PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR. REIMBURSEMENT CUT BACK TO RATE FOR PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR. PER PROVIDER. 5621 PROCEDURE CODE POSA94 SAND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR. PER PROVIDER. 5621 PROCEDURE CODE HOVE CE VALUATION CODE LIMITED TO ONE UNIT A BOA YTIME PERIOD. 5622 CERTAIN MICHELLE P. WAIVER SERVICES ARE LIMITED TO 40 HOURS COMMULATIVELY PER CALENDAR WEEK. 5623 PROCEDURE CODE HOUSE SERVICE SAND LIMITED TO A 40 HOURS COMMULATIVELY PER CALENDAR WEEK. 5624 PROCEDURE CODE HOURS IS LIMITED TO A 40 HOURS COMMUNED AND AND AND AND AND AND AND AND AND AN	5632	LAP HYSTER NOT BILLABLE WITH OTHER HYSTER PROC
CLAIM/DETAIL DENIED. THIS NCCI COLUMN 1 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO A PREVIOUSLY PAID CLAIM/DETAIL DENIED. THIS NCCI COLUMN 2 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO AN NCCI COLUMN 1 (MITATION OF 2 & VISITS PER CALENDAR YEAR EXCEEDED. CLAIM DENIED. LIMIT OF 25 NOCS PER DETAIL EXCEEDED. CLAIM DENIED. LIMIT OF 25 NOCS PER DETAIL EXCEEDED. CLAIM DENIED. LIMIT OF 25 NOCS PER DETAIL EXCEEDED. CLAIM DENIED. LIMIT OF 25 NOCS PER DETAIL EXCEEDED. CLAIM DENIED. LIMIT OF 25 NOCS PER DETAIL EXCEEDED. CLAIM DENIED. LIMIT OF 25 NOCS PER DETAIL EXCEEDED. CLAIM DENIED. LIMIT OF 25 NOCS PER DETAIL EXCEEDED. CLAIM DENIED. LIMIT OF 25 NOCS PER DETAIL EXCEEDED. CLAIM DENIED. LIMIT OF 25 NOCS PER DETAIL EXCEEDED. CLAIM DENIED. LIMIT OF 25 NOCS PER DETAIL EXCEEDED. CLAIM DENIED. LIMIT OF 25 NOCS PER DETAIL EXCEEDED. CESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO TWO PER MEMBER PER PROVIDER PER CALENDAR YEAR. CESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO TWO PER MEMBER PER PROVIDER, PER CALENDAR YEAR. CESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO ONE UNIT PER CALENDAR YEAR. PER PROVIDER. CESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO ONE UNIT PER CALENDAR YEAR. PER CALENDAR YEAR. CESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO ONE UNIT PER CALENDAR YEAR. CESTABLISHED PROCEDURE CODE SOSSA AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR. CESTABLISHED PROCEDURE CODE SOSSA AND 99350 ARE LIMITED TO ONE IN A 30 DAY TIME PERIOD. CESTAIN MICHELLE P. WAINTER SERVICES ARE LIMITED TO ONE IN A 30 DAY TIME PERIOD. CESTAIN MICHELLE P. WAINTER SERVICES ARE LIMITED TO ONE IN A 30 DAY TIME PERIOD. CESTAIN MICHELLE P. WAINTER SERVICES ARE LIMITED TO A DEVIS YEAR. CESTABLISHED PROCEDURE CODE HOOSI IS LIMITED TO A ONE PER CALENDAR MONTH PER MEMBER. CESTABLISHED PROCEDURE CODE IS LIMITED TO A ONE PER CALENDAR WEEK. CESTABLISHED PROCEDURE CODE HOOSI IS LIMITED TO SONE PER CALENDAR WEEK. CESTABLISHED PROCEDURE CODE SOLOSI IS LIMITED TO SONE PER PAY, PER MEMBER. CESTABLISHED PROCEDURE CODE SOLOSI IS LI	5700	CLAIM/DETAIL DENIED. THIS NCCI COLUMN 1 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO A PREVIOUSLY PAID
CLAIM/DETAIL DENIED. THIS NICCI COLUMN 2 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO AN NICCI COLUMN 1 6055 LIMITATION OF 26 VISITS PER CALENDAR YEAR EXCEEDED. 6090 CLAIM DENIED. LIMIT OF 25 NOS PER DETAIL EXCEEDED. 6189 CLAIM/DETAIL DENIED. 99407 IS LIMITED TO 2 UNITS PER CALENDAR YEAR, PER MEMBER. 6200 MEMBERS ARE LIMITED TO OME (1) OPTHAMOLOGICAL EXAMINATION PER PROVIDER PER CALENDAR YEAR. 6201 ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO TWO PER MEMBER PER PROVIDER, PER CALENDAR YEAR. 6210 PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR, PER REMBER PER CONTROLL OF THE CONTROLL OF THE CALENDAR YEAR. 6211 PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR, PER PROVIDER. 6212 CARDIOVASCULAR DEVICE EVALUATION CODE LIMITED TO ONE UNIT PER CALENDAR YEAR, PER PROVIDER. 6213 INTERROGATION DEVICE EVALUATION CODE LIMITED TO ONE IN A 90 DAY TIME PERIOD. 6216 6218 INTERROGATION DEVICE EVALUATION CODE LIMITED TO ONE IN A 90 DAY TIME PERIOD. 6229 CERTAIN MICHELLE P. WANKER SERVICES ARE LIMITED TO ONE PIR A 91 DAY TIME PERIOD. 6230 CERTAIN MICHELLE P. WANKER SERVICES ARE LIMITED TO ONE PIR CALENDAR MONTH PER MEMBER. 6234 PROCEDURE CODE A7048 IS LIMITED TO 40 UNITS (10 HOURS) PER WEEK. 6235 PROCEDURE CODE HO031 IS LIMITED TO 40 UNITS (10 HOURS) PER WEEK. 6236 DETAIL DENIED. PROCEDURE CODE IS LIMITED TO 40 UNITS (10 HOURS) PER WEEK. 6237 PROCEDURE CODE HO032 IS LIMITED TO 16 UNITS (4 HOURS) PER WEEK. 6238 HOME DELIVERED MEALS ARE LIMITED TO SUNTS PER CALENDAR WORTH. 6239 PROCEDURE CODE EVALUS IS LIMITED TO SUNTS PER CALENDAR WORTH, PER MEMBER. 6240 PROCEDURE CODE SOLOS IS LIMITED TO SUNTS PER CALENDAR WORTH, PER MEMBER. 6251 PROCEDURE CODE SOLOS IS LIMITED TO SUNTS PER CALENDAR WORTH, PER MEMBER. 6262 PROCEDURE CODE SOLOS IS LIMITED TO SUNTS PER CALENDAR WORTH, PER MEMBER. 6263 DETAIL DENIED. ADULT DAY HEALTH AND/OR HOME AND COMMUNITY SUPPORTS SERVICES LIMITED TO \$200 PER DAY PER 6264 PROCEDURE CODE SOLOS IS LIMITED	5701	CLAIM/DETAIL DENIED. THIS NCCI COLUMN 2 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO AN NCCI COLUMN 1
LIMITATION OF 26 WISITS PER CALENDAR YEAR EXCEEDED. CLAIM DENIED. LIMIT OF 25 NDCS PER DETAIL EXCEEDED. 6380 CLAIM/DETAIL DENIED. 99407 IS LIMITED TO 2 UNITS PER CALENDAR YEAR, PER MEMBER. 6200 MEMBERS ARE LIMITED TO ONE (1) OPTHAMOLOGICAL EXAMINATION PER PROVIDER PER CALENDAR YEAR. 6210 PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR. REIMBURSEMENT CUT BACK TO RATE FOR PROVIDER. PER CALENDAR YEAR. 6211 PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR. REIMBURSEMENT CUT BACK TO RATE FOR PROVIDER CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR, PER PROVIDER. 6212 CARDIOVASCULAR DEVICE EVALUATION CODE LIMITED TO ONE UNIT PER CALENDAR YEAR, PER PROVIDER. 6213 INTERROGATION DEVICE EVALUATION CODE LIMITED TO ONE UNIT PER CALENDAR YEAR, PER PROVIDER. 6214 INTERROGATION DEVICE EVALUATION CODE LIMITED TO ONE IN A 30 DAY TIME PERIOD. 6215 INTERROGATION DEVICE EVALUATION CODE LIMITED TO ONE IN A 30 DAY TIME PERIOD. 6216 CETATAM MICHELLE P. WAIVERS EXPICES AND LIMITED TO 40 HOURS CLUMMILITATIVELY PER CALENDAR WEEK. 6220 CETATAM MICHELLE P. WAIVERS EXPICES AND LIMITED TO 40 HOURS CLUMMILITATIVELY PER CALENDAR WEEK. 6232 PROCEDURE CODE HOO31 IS LIMITED TO 40 HOURS PER STATE FISCAL YEAR. 6234 PROCEDURE CODE HOO32 IS LIMITED TO 40 HOURS PER STATE FISCAL YEAR. 6235 PROCEDURE CODE HOO32 IS LIMITED TO 16 HOURS PER VEWEY. 6236 DETAIL DENIED. PROCEDURE CODE IS LIMITED TO 16 HOURS PER VEWEY. 6237 PROCEDURE CODE MOO32 IS LIMITED TO 16 BUINTS (CUNCES) PER CALENDAR MONTH. 6238 HOME DELIVERED MEALS ARE LIMITED TO SUNITS PER CALENDAR WEEK, PER MEMBER. 6259 PROCEDURE CODE SOS SIGNO IS LIMITED TO SUNITS PER CALENDAR WEEK, PER MEMBER. 6260 PROCEDURE CODE SOS SIGNO IS LIMITED TO SUNITS PER CALENDAR WEEK, PER MEMBER. 6261 PROCEDURE CODE SOS IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. 6262 PROCEDURE CODE SOS IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. 6263 PROCEDURE CODE SOS IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. 6264 PROCEDURE COD	5702	CLAIM/DETAIL DENIED. THIS NCCI COLUMN 1 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO A PREVIOUSLY PAID
CLAIM/DETAIL DENIED. 19407 IS LIMITED TO 2 UNITS PER CALENDAR YEAR, PER MEMBER. CLAIM/DETAIL DENIED. 99407 IS LIMITED TO 2 UNITS PER CALENDAR YEAR, PER MEMBER. 6200 MEMBERS ARE LIMITED TO ONE (1) OPTHAMOLOGICAL EXAMINATION PER PROVIDER, PER CALENDAR YEAR. 6210 PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO TOW OPER MEMBER PER PROVIDER, PER CALENDAR YEAR. 6211 PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR. REIMBURSEMENT CUT BACK TO RATE FOR 6212 PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR, REIMBURSEMENT CUT BACK TO RATE FOR 6213 PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR, PER PROVIDER. 6214 CARDIOVASCULAR DEVICE EVALUATION CODE LIMITED TO ONE IN A 90 DAY TIME PERIOD. 6215 INTERROGATION DEVICE EVALUATION CODE LIMITED TO ONE IN A 90 DAY TIME PERIOD. 6216 INTERROGATION DEVICE EVALUATION CODE LIMITED TO ONE IN A 90 DAY TIME PERIOD. 6217 PROCEDURE CODE A0048 IS LIMITED TO 40 HOURS CUMMULATIVELY PER CALENDAR WEEK. 6238 PROCEDURE CODE HOO31 IS LIMITED TO 40 HOURS CUMMULATIVELY PER CALENDAR WEEK. 6239 PROCEDURE CODE HOO31 IS LIMITED TO 40 HOURS PER STATE RISCAL YEAR. 6236 DETAIL DENIED. PROCEDURE CODE IS LIMITED TO 40 HOURS PER WEEK. 6237 PROCEDURE CODE HOO32 IS LIMITED TO 40 HOURS PER VERY 24 MONTHS. 6238 HOME DELIVERED MEALS ARE LIMITED TO 50 WINTS (OUNCES) PER CALENDAR MONTH. 6239 HOME DELIVERED MEALS ARE LIMITED TO 180 UNITS (OUNCES) PER CALENDAR MONTH. 6239 HOME DELIVERED MEALS ARE LIMITED TO 50 PER DAY, PER MEMBER. 6250 PROCEDURE CODE S910 IS LIMITED TO 180 UNITS PER CALENDAR WEEK, PER MEMBER. 6251 PROCEDURE CODE S910 IS LIMITED TO 200 UNITS PER CALENDAR WEEK PER MEMBER. 6252 PROCEDURE CODE S910 IS LIMITED TO 0 NO PER CALENDAR MONTH, PER MEMBER. 6253 PROCEDURE CODE S910 IS LIMITED TO 0 ONE PER CALENDAR MONTH, PER MEMBER. 6264 PROCEDURE CODE S910 IS LIMITED TO 0 ONE PER CALENDAR MONTH, PER MEMBER. 6265 PROCEDURE CODE S910 IS LIMITED TO 0 ONE PER CALENDAR WEEK PER MEMBER. 6266 TOTAL AMOUNT ALLOWED FOR GOO	5703	CLAIM/DETAIL DENIED. THIS NCCI COLUMN 2 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO AN NCCI COLUMN 1
CLAIM/DETAIL DENIED. 99407 IS LIMITED TO 2 UNITS PER CALENDAR YEAR, PER MEMBER. MEMBERS ARE LIMITED TO ONE (3) D'HIAMOLOGICAL EXAMINATION PER PROVIDER, PER CALENDAR YEAR. DESCRIPTION PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO TWO PER MEMBER PER PROVIDER, PER CALENDAR YEAR. PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR, REIMBURSEMENT CUT BACK TO RATE FOR PROVIDER, PER PROVIDER. CARDIOVASCULAR DEVICE EVALUATION CODE LIMITED TO ONE UNIT PER CALENDAR YEAR, PER PROVIDER. CESTA INTERROGATION DEVICE EVALUATION CODE LIMITED TO ONE IN A 90 DAY TIME PERIOD. CERTAIN MICHELLE P. WAIVER SERVICES ARE LIMITED TO ONE IN A 30 DAY TIME PERIOD. CERTAIN MICHELLE P. WAIVER SERVICES ARE LIMITED TO 40 HOURS CUMMULATIVELY PER CALENDAR WEEK. CESTA PROCEDURE CODE HO031 IS LIMITED TO 40 UNITS (10 HOURS) PER STATE RISCAL YEAR. PROCEDURE CODE HO031 IS LIMITED TO 16 UNITS (14 HOURS) PER WEEK. CESTA PROCEDURE CODE HO031 IS LIMITED TO 16 UNITS (14 HOURS) PER WEEK. DETAIL DENIED. PROCEDURE CODE BAS IS LIMITED TO 16 UNITS (14 HOURS) PER WEEK. PROCEDURE CODE BA100 IS LIMITED TO 16 UNITS (16 HOURS) PER STATE RISCAL YEAR. PROCEDURE CODE BA100 IS LIMITED TO 16 UNITS (16 HOURS) PER STATE RISCAL YEAR. PROCEDURE CODE BA100 IS LIMITED TO 16 UNITS (16 HOURS) PER STATE RISCAL YEAR. PROCEDURE CODE BA100 IS LIMITED TO 16 UNITS PER CALENDAR MONTH. CESTA PROCEDURE CODE BA100 IS LIMITED TO 16 UNITS PER CALENDAR WEEK, PER MEMBER. PROCEDURE CODE BA100 IS LIMITED TO 10 UNITS PER CALENDAR WEEK, PER MEMBER. PROCEDURE CODE STORE SIGN IS LIMITED TO 20 UNITS PER CALENDAR WEEK, PER MEMBER. CESTA PROCEDURE CODE STORE SIGN IS LIMITED TO 20 UNITS PER CALENDAR WEEK, PER MEMBER. PROCEDURE CODE STORE SIGN IS LIMITED TO 20 UNITS PER CALENDAR WEEK, PER MEMBER. CESTA PROCEDURE CODE STORE SIGN IS LIMITED TO 20 UNITS PER CALENDAR WEEK, PER MEMBER. CESTA PROCEDURE CODE STORE SIGN IS LIMITED TO 3 UNITS PER CALENDAR WEEK, PER MEMBER. CESTA PROCEDURE CODE TO16 IS LIMITED TO 3 UNITS PER CALENDAR WEEK, PER MEMBER. CESTA PROCEDURE	6055	·
MEMBERS ARE LIMITED TO ONE (1) OPTHAMOLOGICAL EXAMINATION PER PROVIDER PER CALENDAR YEAR. ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO TWO PER MEMBER PER PROVIDER, PER CALENDAR YEAR. PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR. REIMBURSEMENT CUT BACK TO RATE FOR CARDIOVASCULAR DEVICE EVALUATION CODE LIMITED TO ONE UNIT PER CALENDAR YEAR. PER PROVIDER. CARDIOVASCULAR DEVICE EVALUATION CODE LIMITED TO ONE IN A 90 DAY TIME PERIOD. INTERROGATION DEVICE EVALUATION CODE LIMITED TO ONE IN A 30 DAY TIME PERIOD. CERTAIN MICHELE P. WAIVER SERVICES ARE LIMITED TO 40 HOURS CUMMULATIVELY PER CALENDAR WEEK. PROCEDURE CODE A003 IS LIMITED TO 40 HOURS CUMMULATIVELY PER CALENDAR WEEK. PROCEDURE CODE HO031 IS LIMITED TO 40 HOURS OF WITH PER MEMBER. CARDIOVACION CODE A0408 IS LIMITED TO 40 HOURS (20 HOURS) PER VIEW. DETAIL DENIED. PROCEDURE CODE HOUSE IS LIMITED TO 40 HOURS) PER WEEK. DETAIL DENIED. PROCEDURE CODE IS LIMITED TO 40 HOURS (20 HOURS) PER WEEK. DETAIL DENIED. PROCEDURE CODE SUINTIED TO 180 UNITS (30 HOURS) PER VIEW. HOME DELIVERED MEALS ARE LIMITED TO 180 UNITS (20 HOURS) PER CALENDAR MONTH. CARDIOVACH MEMBER. HOME DELIVERED MEALS ARE LIMITED TO 50 UNITS PER CALENDAR WEEK, PER MEMBER. DETAIL DENIED. PROCEDURE CODE SOLD SUINTED TO 200 UNITS PER CALENDAR WEEK, PER MEMBER. DETAIL DENIED. ADULT DAY HEALTH AND/OR HOME AND COMMUNITY SUPPORTS SERVICES LIMITED TO \$200 PER DAY PER CESS DETAIL DENIED. ADULT DAY HEALTH AND/OR HOME AND COMMUNITY, PER MEMBER. DETAIL DENIED. ADULT DAY HEALTH AND/OR HOME AND COMMUNITY, PER MEMBER. CESS DETAIL DENIED. ADULT DAY HEALTH AND/OR HOME AND COMMUNITY, PER MEMBER. CESS DETAIL DENIED. ADULT DAY HEALTH AND/OR HOME AND COMMUNITY SUPPORTS SERVICES LIMITED TO \$200 PER DAY PER CESS DETAIL DENIED. ADULT DAY HEALTH AND/OR HOME AND COMMUNITY, PER MEMBER. CESS DETAIL DENIED. THIS PROCEDURE CODE SILIMITED TO TO ONE PER CALENDAR MONTH, PER MEMBER. CESS DETAIL DENIED. THIS PROCEDURE CODE SILIMITED TO TOWN ONLY PER CALENDAR MEMBER. COTAL AMO	6099	CLAIM DENIED. LIMIT OF 25 NDCS PER DETAIL EXCEEDED.
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PROCEDURE CODE B4100 IS LIMITED TO 180 UNITS (OUNCES) PER CALENDAR MONTH. 6238 HOME DELIVERED MEALS ARE LIMITED TO ONE PER DAY, PER MEMBER. 6239 HOME DELIVERED MEALS ARE LIMITED TO 5 UNITS PER CALENDAR WEEK, PER MEMBER. 6257 PROCEDURE CODE S5100 IS LIMITED TO 200 UNITS PER CALENDAR WEEK PER MEMBER. 6258 DETAIL DENIED. ADULT DAY HEALTH AND/OR HOME AND COMMUNITY SUPPORTS SERVICES LIMITED TO \$200 PER DAY PER 6259 PROCEDURE CODE T1016 IS LIMITED TO 0 ONE PER CALENDAR MONTH, PER MEMBER. 6260 PROCEDURE CODE 99188 IS LIMITED TO 2 UNITS PER CALENDAR YEAR. 6261 REVENUE CODE 590 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. 6262 PROCEDURE CODE T2040, MODIFIER HI, IS LIMITED TO TWO UNITS PER CALENDAR MONTH, PER MEMBER. 6263 REVENUE CODE 590 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. 6264 PROCEDURE CODE T2040, MODIFIER HI, IS LIMITED TO TWO UNITS PER CALENDAR MONTH, PER MEMBER. 6265 TOTAL AMOUNT ALLOWED FOR ENVIRONMENTAL AND MINOR HOME ADAPTATION HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF 6266 TOTAL AMOUNT ALLOWED FOR GOODS AND SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF CARE YEAR. 6270 DETAIL DENIED. EXCEEDS THE \$200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER. 6280 DETAIL DENIED. EXCEEDS THE \$200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER. 6281 DETAIL DENIED. EXCEEDS THE \$200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER. 6304 DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. 6305 ENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR PER MEMBER. 6306 ENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR MEMBER. 6307 DENTAL PROCEDURE CODE D7960 IS LIMITED TO TO WUNITS PER DATE OF SERVICE PER MEMBER. 6308 COMMUNITY LIVING SUPPORTS IS LIMITED TO 100 UNITS PER CALENDAR WEEK FOR ABI LITCMEMBERS. 6310 NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LITCMEMBERS. 6311 NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LITCMEMBERS. 6312 FAMILY TRAINING	6235	PROCEDURE CODE H0032 IS LIMITED TO 16 UNITS (4 HOURS) PER WEEK.
HOME DELIVERED MEALS ARE LIMITED TO ONE PER DAY, PER MEMBER. 6239 HOME DELIVERED MEALS ARE LIMITED TO 5 UNITS PER CALENDAR WEEK, PER MEMBER. 6257 PROCEDURE CODE \$5100 IS LIMITED TO 200 UNITS PER CALENDAR WEEK PER MEMBER. 6258 DETAIL DENIED. ADULT DAY HEALTH AND/OR HOME AND COMMUNITY SUPPORTS SERVICES LIMITED TO \$200 PER DAY PER 6259 PROCEDURE CODE 1016 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. 6260 PROCEDURE CODE 99188 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. 6261 PROCEDURE CODE 590 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. 6262 PROCEDURE CODE 590 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. 6263 REVENUE CODE 590 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. 6264 PROCEDURE CODE 12040, MODIFIER HI, IS LIMITED TO TWO UNITS PER CALENDAR MONTH, PER MEMBER. 6265 TOTAL AMOUNT ALLOWED FOR ENVIRONMENTAL AND MINOR HOME ADAPTATION HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF 6266 TOTAL AMOUNT ALLOWED FOR GOODS AND SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF CARE YEAR. 6267 DETAIL DENIED. EXCEEDS THE \$200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER. 6289 DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. 6304 DETAIL DENIED. HESPITE SERVICE ARE LIMITED TO \$4000.00 PER CALENDAR YEAR. 6305 ENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR MONTH. 6306 FINANCIAL MANAGEMENT IS LIMITED TO 8 UNITS PER MEMBER, PER PROVIDER, PER CALENDAR MONTH. 6307 DENTAL PROCEDURE CODE D7960 IS LIMITED TO THOU UNITS PER DATE OF SERVICE PER MEMBER. 6308 COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. 6310 NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. 6310 NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. 6310 NURSING SUPPORTS SERVICES ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. 6311 FINANCIAL MANAGEMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI L	6236	DETAIL DENIED. PROCEDURE CODE IS LIMITED TO TWO EVERY 24 MONTHS.
HOME DELIVERED MEALS ARE LIMITED TO 5 UNITS PER CALENDAR WEEK, PER MEMBER. PROCEDURE CODE \$5100 IS LIMITED TO 200 UNITS PER CALENDAR WEEK PER MEMBER. DETAIL DENIED. ADULT DAY HEALTH AND/OR HOME AND COMMUNITY SUPPORTS SERVICES LIMITED TO \$200 PER DAY PER PROCEDURE CODE \$1016 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. PROCEDURE CODE \$90 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. REVENUE CODE \$90 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. PROCEDURE CODE \$90 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. PROCEDURE CODE \$90 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. PROCEDURE CODE \$90 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. PROCEDURE CODE \$90 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. PROCEDURE CODE \$1040, MODIFIER HI, IS LIMITED TO TWO UNITS PER CALENDAR MONTH, PER MEMBER. TOTAL AMOUNT ALLOWED FOR ENVIRONMENTAL AND MINOR HOME ADAPTATION HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF CARE YEAR. DETAIL DENIED. EXCEEDS THE \$200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER'S LEVELOF CARE YEAR. DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO \$4000.00 PER CALENDAR YEAR, PER MEMBER. POTAL AMOUNT ALLOWED FOR RESPITE SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVELOF CARE YEAR. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO \$4000.00 PER CALENDAR YEAR. PENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR PER MEMBER. PROVIDEN PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER. DETAIL PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER. ADULT DAY TRAINING AND SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THE PROVIDENCE ONLY TO SUNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THE PROVIDENCE CODE STOURS AND SISSA ARE LIMITED TO ONE UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THIS PRO	6237	PROCEDURE CODE B4100 IS LIMITED TO 180 UNITS (OUNCES) PER CALENDAR MONTH.
DETAIL DENIED. EXCEEDS THE \$200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER. DETAIL DENIED. ADULT JUNIOR FOR GOODS AND SERVICES HAS BEEN EXCEEDED FOR MEMBERS. DETAIL DENIED. EXCEEDS THE SERVICE SERVICE SLIMITED TO SUNITS PER CALENDAR MONTH, PER MEMBER. DETAIL DENIED. EXCEEDS THE SERVICE SERVICES HAS BEEN EXCEEDED FOR MEMBER. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. DETAIL DENIED. EXCEEDS THE \$200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER. DETAIL DENIED. EXCEEDS THE \$200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO ONE PER CALENDAR YEAR. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO ONE PER CALENDAR YEAR. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO ONE PER CALENDAR YEAR. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO SAUD SER CALENDAR YEAR. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO SUNITS PER DATE OF SERVICE PER MEMBER. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO SUNITS PER DATE OF SERVICE PER MEMBER. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO SUNITS PER DATE OF SERVICE PER MEMBER. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO SUNITS PER DATE OF SERVICE PER MEMBER. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO SUNITS PER DATE OF SERVICE PER MEMBER. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO SUNITS PER DATE OF SERVICE PER MEMBER. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO SUNITS PER DATE OF SERVICE PER MEMBER. DENTAL PROCEDURE CODE D7960 IS LIMITED TO 160 UNITS PER DATE OF SERVICE PER MEMBER. DENTAL PROCEDURE SUDPORTS IS LIMITED TO 38 UNITS PER CALENDAR WEEK FOR ABILTCMEMBERS. DENTAL PROCEDURE SERVICES ARE LIMITED TO 38 UNITS PER CALENDAR WEEK FOR ABILTCMEMBERS. DENTAL PROCEDURE SERVICES ARE LIMITED TO ARE LIMITED TO SOOD.00 PER CALENDAR YEARFOR MEMBERS IN THE ABILTC FAMILY TRAINING IS LIMITED TO 16 UNITS PER CALENDAR WEEK FOR ABILTCMEMBERS. DENTAL PROCEDURE IS LIMITED TO 16 UNITS PER DAY.	6238	HOME DELIVERED MEALS ARE LIMITED TO ONE PER DAY, PER MEMBER.
DETAIL DENIED. ADULT DAY HEALTH AND/OR HOME AND COMMUNITY SUPPORTS SERVICES LIMITED TO \$200 PER DAY PER PROCEDURE CODE T1016 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. PROCEDURE CODE 99188 IS LIMITED TO 2 UNITS PER CALENDAR MONTH, PER MEMBER. REVENUE CODE 590 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. PROCEDURE CODE 590 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. PROCEDURE CODE T2040, MODIFIER HI, IS LIMITED TO TWO UNITS PER CALENDAR MONTH, PER MEMBER. TOTAL AMOUNT ALLOWED FOR ENVIRONMENTAL AND MINOR HOME ADAPTATION HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF TOTAL AMOUNT ALLOWED FOR GOODS AND SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF CARE YEAR. DETAIL DENIED. EXCEEDS THE \$200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER. TOTAL AMOUNT ALLOWED FOR RESPITE SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVELOF CARE YEAR. DETAIL DENIED. HIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. DETAIL DENIED. RESPITE SERVICE AND ES LIMITED TO SEVEN EXCEEDED FOR MEMBER'S LEVELOF CARE YEAR. DETAIL DENIED. RESPITE SERVICE AND LIMITED TO SEVEN EXCEEDED FOR MEMBER'S LEVELOF CARE YEAR. BURNONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR PER MEMBER. FINANCIAL MANAGEMENT IS LIMITED TO A UNITS PER MEMBER, PER PROVIDER, PER CALENDAR MONTH. DENTAL PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER. DENTAL PROCEDURE CODE D7960 IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. ADULT DAY TRAINING AND SUPPORTS IS LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. BURNONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$200.00 PER CALENDAR WEEK FOR ABI LTC MEMBERS. FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY.	6239	HOME DELIVERED MEALS ARE LIMITED TO 5 UNITS PER CALENDAR WEEK, PER MEMBER.
PROCEDURE CODE T1016 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. PROCEDURE CODE 99188 IS LIMITED TO 2 UNITS PER CALENDAR YEAR. REVENUE CODE 590 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. PROCEDURE CODE T2040, MODIFIER HI, IS LIMITED TO TWO UNITS PER CALENDAR MONTH, PER MEMBER. TOTAL AMOUNT ALLOWED FOR ENVIRONMENTAL AND MINOR HOME ADAPTATION HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF TOTAL AMOUNT ALLOWED FOR GOODS AND SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF CARE YEAR. DETAIL DENIED. EXCEEDS THE \$200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER. TOTAL AMOUNT ALLOWED FOR RESPITE SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF CARE YEAR. DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO \$4000.00 PER CALENDAR YEAR. BINIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR PER MEMBER. BINIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR MONTH. DENTAL PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER. COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ADULT DAY TRAINING AND SUPPORTS IS LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ADULT DAY TRAINING AND SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. BINIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. FANIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC FAMILY TRAINING IS LIMITED TO 16 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. PROVIDED THE PROCEDURE IS LIMITED TO 16 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. PROVIDED THE PROCEDURE IS LIMITED TO 16 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS.	6257	PROCEDURE CODE S5100 IS LIMITED TO 200 UNITS PER CALENDAR WEEK PER MEMBER.
PROCEDURE CODE 99188 IS LIMITED TO 2 UNITS PER CALENDAR YEAR. REVENUE CODE 590 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. PROCEDURE CODE T2040, MODIFIER HI, IS LIMITED TO TWO UNITS PER CALENDAR MONTH, PER MEMBER. TOTAL AMOUNT ALLOWED FOR ENVIRONMENTAL AND MINOR HOME ADAPTATION HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF TOTAL AMOUNT ALLOWED FOR GOODS AND SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF CARE YEAR. DETAIL DENIED. EXCEEDS THE \$200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER. TOTAL AMOUNT ALLOWED FOR RESPITE SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVELOF CARE YEAR. DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. BIVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR PER MEMBER. SOOG FINANCIAL MANAGEMENT IS LIMITED TO 8 UNITS PER MEMBER, PER PROVIDER, PER CALENDAR MONTH. DENTAL PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBERS. ADULT DAY TRAINING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 500.00 PER CALENDAR WEEK FOR ABI LTC MEMBERS. AURSING SUPPORTS SERVICES ARE LIMITED TO 128 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. BIVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO 160 UNITS PER CALENDAR YEAR FOR ABI LTCMEMBERS. ENVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6258	DETAIL DENIED. ADULT DAY HEALTH AND/OR HOME AND COMMUNITY SUPPORTS SERVICES LIMITED TO \$200 PER DAY PER
REVENUE CODE 590 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. 6264 PROCEDURE CODE T2040, MODIFIER HI, IS LIMITED TO TWO UNITS PER CALENDAR MONTH, PER MEMBER. 6265 TOTAL AMOUNT ALLOWED FOR ENVIRONMENTAL AND MINOR HOME ADAPTATION HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF 6266 TOTAL AMOUNT ALLOWED FOR GOODS AND SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF CARE YEAR. 6267 DETAIL DENIED. EXCEEDS THE \$200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER. 6285 TOTAL AMOUNT ALLOWED FOR RESPITE SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF CARE YEAR. 6289 DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. 6304 DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO \$4000.00 PER CALENDAR YEAR. 6305 ENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR PER MEMBER. 6306 FINANCIAL MANAGEMENT IS LIMITED TO 8 UNITS PER MEMBER, PER PROVIDER, PER CALENDAR MONTH. 6307 DENTAL PROCEDURE CODE 07960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER. 6308 COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. 6309 ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. 6310 NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. 6318 ENVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC 6319 FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. 6320 THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. 6321 PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6259	PROCEDURE CODE T1016 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER.
PROCEDURE CODE T2040, MODIFIER HI, IS LIMITED TO TWO UNITS PER CALENDAR MONTH, PER MEMBER. TOTAL AMOUNT ALLOWED FOR ENVIRONMENTAL AND MINOR HOME ADAPTATION HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF TOTAL AMOUNT ALLOWED FOR GOODS AND SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF CARE YEAR. DETAIL DENIED. EXCEEDS THE \$200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER. TOTAL AMOUNT ALLOWED FOR RESPITE SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVELOF CARE YEAR. DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO \$4000.00 PER CALENDAR YEAR. ENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR PER MEMBER. FINANCIAL MANAGEMENT IS LIMITED TO 8 UNITS PER MEMBER, PER PROVIDER, PER CALENDAR MONTH. DENTAL PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER. COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ANURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. BINVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6262	PROCEDURE CODE 99188 IS LIMITED TO 2 UNITS PER CALENDAR YEAR.
TOTAL AMOUNT ALLOWED FOR ENVIRONMENTAL AND MINOR HOME ADAPTATION HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF COMMUNITY ALLOWED FOR GOODS AND SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF CARE YEAR. DETAIL DENIED. EXCEEDS THE \$200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER. TOTAL AMOUNT ALLOWED FOR RESPITE SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVELOF CARE YEAR. DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO \$4000.00 PER CALENDAR YEAR. ENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR PER MEMBER. FINANCIAL MANAGEMENT IS LIMITED TO 8 UNITS PER MEMBER, PER PROVIDER, PER CALENDAR MONTH. DENTAL PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER. COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. BINIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6263	REVENUE CODE 590 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER.
TOTAL AMOUNT ALLOWED FOR GOODS AND SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF CARE YEAR. DETAIL DENIED. EXCEEDS THE \$200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER. TOTAL AMOUNT ALLOWED FOR RESPITE SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVELOF CARE YEAR. DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO \$4000.00 PER CALENDAR YEAR. ENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR MONTH. SINCE PER MEMBER. DENIAL PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER. COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. BENVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6264	PROCEDURE CODE T2040, MODIFIER HI, IS LIMITED TO TWO UNITS PER CALENDAR MONTH, PER MEMBER.
DETAIL DENIED. EXCEEDS THE \$200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER. TOTAL AMOUNT ALLOWED FOR RESPITE SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVELOF CARE YEAR. DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. BETAIL DENIED. RESPITE SERVICE ARE LIMITED TO \$4000.00 PER CALENDAR YEAR. ENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR MONTH. BINANCIAL MANAGEMENT IS LIMITED TO 8 UNITS PER MEMBER, PER PROVIDER, PER CALENDAR MONTH. DENTAL PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER. COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. BINIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. PROCEDURE CODES T2033 AND SS136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6265	TOTAL AMOUNT ALLOWED FOR ENVIRONMENTAL AND MINOR HOME ADAPTATION HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF
TOTAL AMOUNT ALLOWED FOR RESPITE SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVELOF CARE YEAR. DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. BETAIL DENIED. RESPITE SERVICE ARE LIMITED TO \$4000.00 PER CALENDAR YEAR. ENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR PER MEMBER. FINANCIAL MANAGEMENT IS LIMITED TO 8 UNITS PER MEMBER, PER PROVIDER, PER CALENDAR MONTH. DENTAL PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER. COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ENVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6266	TOTAL AMOUNT ALLOWED FOR GOODS AND SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF CARE YEAR.
DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO \$4000.00 PER CALENDAR YEAR. ENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR PER MEMBER. FINANCIAL MANAGEMENT IS LIMITED TO 8 UNITS PER MEMBER, PER PROVIDER, PER CALENDAR MONTH. DENTAL PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER. COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ENVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6267	DETAIL DENIED. EXCEEDS THE \$200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER.
DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO \$4000.00 PER CALENDAR YEAR. ENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR PER MEMBER. FINANCIAL MANAGEMENT IS LIMITED TO 8 UNITS PER MEMBER, PER PROVIDER, PER CALENDAR MONTH. DENTAL PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER. COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. BIVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6285	TOTAL AMOUNT ALLOWED FOR RESPITE SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVELOF CARE YEAR.
ENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR PER MEMBER. FINANCIAL MANAGEMENT IS LIMITED TO 8 UNITS PER MEMBER, PER PROVIDER, PER CALENDAR MONTH. DENTAL PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER. COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ENVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6289	DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER.
FINANCIAL MANAGEMENT IS LIMITED TO 8 UNITS PER MEMBER, PER PROVIDER, PER CALENDAR MONTH. DENTAL PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER. COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ENVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6304	DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO \$4000.00 PER CALENDAR YEAR.
DENTAL PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER. COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ENVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6305	ENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO \$500.00 PER CALENDAR PER MEMBER.
COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ENVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6306	FINANCIAL MANAGEMENT IS LIMITED TO 8 UNITS PER MEMBER, PER PROVIDER, PER CALENDAR MONTH.
ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ENVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6307	DENTAL PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER.
NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. ENVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6308	COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS.
6318 ENVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC 6319 FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. 6320 THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. 6321 PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6309	ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS.
6319 FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. 6320 THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. 6321 PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6310	NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS.
THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6318	ENVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO \$2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABILTC
PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.	6319	FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS.
	6320	THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY.
OCCUPATIONAL THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR ABI LTC MEMBERS.	6321	PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.
	6323	OCCUPATIONAL THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR ABI LTC MEMBERS.

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6324	SPEECH THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR ABI LTC MEMBERS.
6325	PHYSICAL THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR ABILITC MEMBERS.
6326	
6327	RESPITE SERVICES ARE LIMITED TO 1,440 HOURS PER MEMBER, PER CALENDAR YEAR FOR ABILTE MEMBERS.
	ADULT DAY HEALTH CARE IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABILTC MEMBERS.
6328	CLAIM/DETAIL DENIED. PROCEDURE(S) LIMITED TO FOUR UNITS PER DATE OF SERVICE.
6329	PROCEDURE CODE D1208 IS LIMITED TO TWO UNITS PER YEAR.
6330	THIS PROCEDURE IS LIMITED TO ONE PER LIFETIME, PER MEMBER.
6331	THIS PROCEDURE IS LIMITED TO ONE PER LIFETIME, PER MEMBER, PER LOWER QUADRANT.
6332	DENTAL PROCEDURE CODE D1208 IS LIMITED TO TWO PER YEAR PER MEMBER.
6333	CLAIM DENIED. PROCEDURE CODES 64492 AND 64495 ARE EACH LIMITED TO ONE UNIT PERDAY.
6334	CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO 336 HOURS PER MEMBER, PERPROVIDER, PER 12 MONTHS.
6335	CLAIM/DETAIL DENIED. HOME MODIFICATIONS ARE LIMITED TO \$2000.00 PER MEMBER, PER PROVIDER, PER 12 MONTHS.
6336	CLAIM/DETAIL DENIED. ONLY ONE UNIT OF SUPERVISED RESIDENTIAL CARE IS PAYABLE PER DAY, PER MEMBER, PER PROVIDER.
6337	CLAIM DETAIL DENIED OR PAYMENT REDUCED. RESPITE IS LIMITED TO \$4000.00 PER 365DAYS FOR THIS MEMBER.
6338	ONLY ONE UNIT OF RESIDENTIAL SERVICES CAN BE BILLED PER DAY PER PROVIDER FOR ANSCL2 MEMBER.
6339	CERTAIN SCL2 SERVICES ARE LIMITED TO 64 UNITS CUMULATIVELY PER DAY FOR SCL2 MEMBERS.
6340	DAY TRAINING CANNOT BE BILLED MORE THAN 5 DAYS DURING A CALENDAR WEEK FOR AN SCL2 MEMBER.
6341	OCCUPATIONAL THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR AN SCL2 MEMBER.
6342	SPEECH THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR AN SCL2 MEMBER.
6343	PHYSICAL THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR AN SCL2 MEMBER.
6344	DAY TRAINING AND SUPPORTED EMPLOYMENT LIMITED TO 160 CUMULATIVE UNITS PER CALENDAR WEEK FOR AN SCL2 MEMBER.
6345	COMMUNITY ACCESS SERVICES ARE LIMITED TO 160 CUMULATIVE UNITS PER CALENDAR WEEKFOR SCL2 MEMBERS.
6346	TRANSPORTATION NON-RESIDENTIAL SERVICES ARE LIMITED TO \$265.00 PER CALENDAR MONTH FOR AN SCL2 MEMBER.
6347	SHARED LIVING SERVICES ARE LIMITED TO \$600.00 PER CALENDAR MONTH FOR SCL2 MEMBERS.
6348	VEHICLE ADAPTATION SERVICES ARE LIMITED TO \$6000.00 PER 5 YEARS FOR AN SCL2 MEMBER.
6349	ENVIRONMENTAL ACCESSIBILITY SERVICES LIMITED TO \$8000.00 FOR THIS TIME PERIOD.
6350	T1005 IS LIMITED TO 3,320 UNITS OF SERVICE DURING AN SCL2 MEMBER'S PLAN OF CAREPERIOD.
6351	T1999 IS LIMITED TO \$1800.00 DURING AN SCL2 MEMBER'S PLAN OF CARE PERIOD.
6352	H0023 IS LIMITED TO 1,320 UNITS OF SERVICE DURING AN SCL2 MEMBER'S PLAN OF CAREPERIOD.
6353	H0004 IS LIMITED TO 160 UNITS OF SERVICE DURING AN SCL2 MEMBER'S PLAN OF CARE PERIOD.
6354	H2015 IS LIMITED TO 576 UNITS OF SERVICE DURING AN SCL2 MEMBER'S PLAN OF CARE PERIOD.
6355	PROCEDURE CODES 90832, 90834, 90835, 90887 AND H0004 ARE LIMITED CUMULATIVELY TO 4 HOURS PER DAY PER MEMBER.
6356	PROCEDURE CODES 90832, 90834, 90835, 90887 AND H0004 ARE LIMITED CUMULATIVELY TO 16 HOURS PER CALENDAR WEEK PER
6357	PROCEDURE CODE T1023 IS LIMITED TO 5 UNITS PER CALENDAR MONTH PER MEMBER.
6358	PROCEDURE CODE 90853 IS LIMITED TO 12 UNITS PER DAY PER MEMBER.
6359	PROCEDURE CODE 90853 IS LIMITED TO 36 UNITS PER CALENDAR WEEK PER MEMBER.
6360	PROCEDURE CODE T2023 IS LIMITED TO 1 UNIT PER CALENDAR MONTH PER MEMBER.
6361	PROCEDURE CODE T2012 IS LIMITED TO 7 HOURS PER DAY PER MEMBER.
6362	PROCEDURE CODE S9480 IS LIMITED TO 3 HOURS PER DAY PER MEMBER.
6363	PROCEDURE CODE S9480 IS LIMITED TO 15 HOURS PER CALENDAR WEEK PER MEMBER.
6364	PROCEDURE CODE H2019, MODIFIER UG, IS LIMITED TO 16 UNITS PER DAY PER MEMBER.
6365	PROCEDURE CODE H2019, EXCLUDING MODIFIER UG, IS LIMITED TO 24 UNITS/DAY PER MEMBER.
6366	PROCEDURE CODE S9485 IS LIMITED TO TEN CONSECUTIVE DAYS.
6367	PROCEDURE CODE H2021, MODIFIERS HM, HN & HS, IS LIMITED CUMULATIVELY TO 16 UNITS/DAY.
6368	PROCEDURE CODE S5145 IS LIMITED TO ONE UNIT PER DATE OF SERVICE PER MEMBER.
6370	T2025 IS LIMITED TO \$1,000.00 DURING AN SCL2 MEMBER'S PLAN OF CARE PERIOD.
6371	NEW PATIENT DOMICIARY, REST HOME, AND CUSTODIAL CARE SERVICES ARE LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36
6377	PROCEDURE CODE 83655, MODIFIERS 33 AND U7, IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER.
6378	MEMBERS 0 THRU 15 MONTHS OF AGE ALLOWED SIX EPSDT/WELL CHILD VISIT PROCEDURES WHEN BILLED WITH MODIFIERS 33 AND
6379	CERVICAL CANCER SCREENING IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER.
6380	PROCEDURE CODE S9485 LIMITED TO ONE PER DAY, PER MEMBER.
6381	PROCEDURE CODE A6545 IS LIMITED TO TWO PER LEG PER MEMBER PER CALENDAR YEAR.
6383	ONE COLON CANCER SCREENING PROCEDURE ALLOWED WHEN BILLED WITH MODIFIERS 33 AND U7 PER CALENDAR YEAR, PER
6384	SPIROMETRY TESTING FOR ASSESSMENT AND DIAGNOSIS OF COPD IS LIMITED TO 1 PER CALENDAR YEAR, PER MEMBER.
6385	PROCEDURE CODE A5057 IS LIMITED TO 31 UNITS PER CALENDAR MONTH PER MEMBER. PRIOR AUTHORIZATION REQUIRED FOR
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ONE NUTRITION AND ONE PHYSICAL ACTIVITY COUNSELING PROCEDURE ALLOWED PER MEMBER, PER CALENDAR YEAR, PROCEDURE FOR CONTROLLING BLOOD PRESSURE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. PROCEDURE CODE S3189 IS LIMITED TO TWO PER CALENDAR MONTH PER MEMBER. PROCEDURE CODE D3354 IS LIMITED TO 2 UNITS PER 6 CALENDAR MONTH PER MEMBER. PROCEDURE CODE D3354 IS LIMITED TO 2 UNITS PER 6 CALENDAR MONTH S. PROCEDURE CODE D3354 IS LIMITED TO 2 UNITS PER 6 CALENDAR MONTH S. PROCEDURE CODE D3354 IS LIMITED TO 2 UNITS PER COLENDAR WEEK FOR MEMBER PER CALENDARYEAR. PROCEDURE CODE D3354 IS LIMITED TO 2 UNITS PER TOOTH PER MEMBER PER CALENDARYEAR. PROCEDURE CODE D3354 IS LIMITED TO 31 UNITS PER TOOTH PER MEMBER PER S1K MONTHS. PROCEDURE CODE A9276 IS LIMITED TO 31 UNITS PER TOOTH PER MEMBER PER CALENDAR MONTH. PROCEDURE CODE A9276 IS LIMITED TO 31 UNITS PER MEMBER PER CALENDAR MONTH. PROCEDURE CODE A9276 IS LIMITED TO 31 UNITS PER MEMBER PER CALENDAR WORTH. PROCEDURE CODE A9276 IS LIMITED TO 10 UNITS PER MEMBER PER CALENDAR WORTH. PROCEDURE CODE A9276 IS LIMITED TO 10 UNITS PER MEMBER PER CALENDAR YEAR. PROCEDURE CODE A9276 IS LIMITED TO TO WE UNITS PER CALENDAR MONTH PER MEMBER. PROCEDURE CODE A9278 IS LIMITED TO TO WE UNITS PER CALENDAR MONTH PER MEMBER. PROCEDURE CODE A9228 IS LIMITED TO THE WINTS PER CALENDAR MONTH PER MEMBER. PROCEDURE CODE A9228 IS LIMITED TO FIFTEEN UNITS PER CALENDAR MONTH PER MEMBER. PROCEDURE CODE A9228 IS LIMITED TO FIFTEEN UNITS PER CALENDAR MONTH PER MEMBER. PROCEDURE CODE IS LIMITED TO 2 UNITS PER SIX MONTHS. PROCEDURE CODE IS LIMITED TO SUNTS PER SIX MONTHS. PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. PROCEDURE CODE IS LIMITED TO 3 UNITS, PER MEMBER, PER CALENDAR WEEK. PROCEDURE CODE IS LIMITED TO 3 UNITS, PER MEMBER, PER CALENDAR WEEK. PROCEDURE CODE IS LIMITED TO 3 UNITS, PER ME	EOB Code	Description
PROCEDURE COD FASTS IS LIMITED TO SUNTS PER CALENDAR WORTH CONTROLLED AND PER CALENDAR WORTH. 3890 PROCEDURE COD PLASA IS LIMITED TO A UNITS PER CALENDAR MONTH SER MEMBER. 3891 PROCEDURE COD PLASA IS LIMITED TO A UNITS PER CALENDAR WORTH. 3892 PROCEDURE CODE AND AS IS LIMITED TO A UNITS PER CALENDAR WEEK FOR MEMBER PER CALENDARVEAR. 3893 PROCEDURE CODE AS IS LIMITED TO A UNITS PER LIMITED TO THE MEMBER PER CALENDAR WORTH. 3894 PROCEDURE CODE AS IS LIMITED TO THE WORTH SER CALENDAR WEEK FOR MEMBER PER SIM MONTHS. 3895 PROCEDURE CODE AS IS LIMITED TO TWO UNITS PER MEMBER PER CALENDAR WORTH. 3896 PROCEDURE CODE AS IS LIMITED TO ALL UNITS PER MEMBER PER CALENDAR WORTH. 3897 PROCEDURE CODE AS IS LIMITED TO ALL UNITS PER MEMBER PER CALENDAR WEAK. 3898 PROCEDURE CODE AS IS LIMITED TO ALL UNITS PER MEMBER PER CALENDAR WEAK. 3899 PROCEDURE CODE AS IS LIMITED TO THE UNITS PER CALENDAR MONTH. 3899 PROCEDURE CODE AS IS LIMITED TO SERVICE, WINTS PER CALENDAR MONTH PER MEMBER. 3890 PROCEDURE CODE AS IS LIMITED TO FITTEN UNITS PER CALENDAR MONTH PER MEMBER. 3890 PROCEDURE CODE AS IS LIMITED TO FITTEN UNITS PER CALENDAR MONTH PER MEMBER. 3891 PROCEDURE CODE AS IS LIMITED TO FITTEN UNITS PER CALENDAR MONTH PER MEMBER. 3892 PROCEDURE CODE AS IS LIMITED TO FITTEN UNITS PER CALENDAR MONTH PER MEMBER. 3894 PROCEDURE CODE AS IS LIMITED TO FITTEN UNITS PER CALENDAR MONTH PER MEMBER. 3894 PROCEDURE CODE AS IS LIMITED TO SERVICE. 3994 PROCEDURE CODE IS LIMITED TO SERVICE. 3994 PROCEDURE CODE IS LIMITED TO SERVICE. 3994 PROCEDURE CODE IS LIMITED TO SERVICE. 3995 PROCEDURE CODE IS LIMITED TO SERVICE. 3996 PROCEDURE CODE IS LIMITED TO SERVICE. 3997 PROCEDURE CODE IS LIMITED TO SERVICE. 3998 PROCEDURE CODE IS LIMITED TO SERVICE. 3999 PROCEDURE CODE IS LIMITED TO SERVICE. 3990 PROCEDURE CODE IS LIMI		·
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PROCEDURE CODE DISSA IS LIMITED TO 2 UNITS PER GLAINDAR MONTHS. 5391 PROCEDURE CODE DISSA IS LIMITED TO 20 UNITS PER QUADRANT PER MEMBER PER CALENDARYEAR. 5392 SERVICES ARE LIMITED TO 40 HOURS PER CALENDAR WEEK FOR MEMBERS IN THE MICHELLEPWAIVER PROGRAM. 5393 PROCEDURE CODE DISSA IS LIMITED TO 31 UNITS PER TOOTH PER MEMBER PER SIX MONTHS. 5394 PROCEDURE CODE AS278 IS LIMITED TO 31 UNITS PER TOOTH PER MEMBER PER CALENDAR WORTH. 5395 PROCEDURE CODE AS278 IS LIMITED TO 31 UNITS PER MEMBER PER CALENDAR MONTH. 5396 PROCEDURE CODE AS277 IS LIMITED TO ONE UNIT PER MEMBER PER CALENDAR WORTH. 5397 PROCEDURE CODE AS277 IS LIMITED TO INVO UNITS PER MEMBER PER CALENDAR WORTH. 5398 PROCEDURE CODE AS272 IS LIMITED TO INVO UNITS PER MEMBER PER CALENDAR WORTH. 5399 PROCEDURE CODE AS272 IS LIMITED TO INVO UNITS PER MEMBER PER CALENDAR WORTH PER MEMBER. 5399 PROCEDURE CODE AS273 IS LIMITED TO INVO UNITS PER CALENDAR MONTH PER MEMBER. 5399 PROCEDURE CODE AS275 IS LIMITED TO INVO UNITS PER CALENDAR MONTH PER MEMBER. 5401 THIS SERVICE IS LIMITED TO G UNITS PER SIX MONTHS. 5402 VACCIN COLUNS EINING PROCEDURE CODE SOAD IS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER DATE OF SERVICE. 5403 VACCIN COLUNS EINING PROCEDURE CODE SOAD IS LIMITED TO A PER MEMBER PER PER AR. 5404 VACCIN COLUNS EINING PROCEDURE CODE SOAD IS LIMITED TO A PER MEMBER PER PER AR. 5405 VACCIN COLUNS EINING PROCEDURE CODE SOAD IS CALENDAR MONTH POR SCL2 MEMBERS. 5406 PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. 5407 PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. 5408 PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. 5409 SHARED LIVING SERVICES ARE LIMITED TO 5726.00 PER CALENDAR WEEK. 5410 PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. 5411 PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. 5412 PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR WEEK. 5413 PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR WEEK.	-	·
PROCEDURE CODE DI354 IS LIMITED TO 2 JUNITS PER QUADRANT PER MEMBER PER CALENDARVEAR. 3931 PROCEDURE CODE 1354 IS LIMITED TO TWO UNITS PER TOOTH PER MEMBER PER SIX MONTHS. 3932 PROCEDURE CODE 32276 IS LIMITED TO TWO UNITS PER TOOTH PER MEMBER PER SIX MONTHS. 3934 PROCEDURE CODE 32276 IS LIMITED TO TWO UNITS PER TOOTH PER MEMBER PER SIX MONTHS. 3936 PROCEDURE CODE 32278 IS LIMITED TO TWO UNITS PER MEMBER PER CALENDAR WERR. 3937 PROCEDURE CODE 32272 IS LIMITED TO TWO UNITS PER MEMBER PER CALENDAR VERR. 3939 PROCEDURE CODE 32272 AND D9223 AND LIMITED TO TWO UNITS PER MEMBER PER CALENDAR VERR. 3939 PROCEDURE CODE 32227 AND D9223 AND LIMITED TO TWO UNITS PER MEMBER PER CALENDAR VERR. 3939 PROCEDURE CODE A2221 IS LIMITED TO FIVE UNITS PER CALENDAR MONTH PER MEMBER. 3939 PROCEDURE CODE A2221 IS LIMITED TO FIVE UNITS PER CALENDAR MONTH PER MEMBER. 3940 PROCEDURE CODE A2221 IS LIMITED TO FIVE UNITS PER CALENDAR MONTH PER MEMBER. 4051 THIS SERVICE IS LIMITED TO GUITS PER SIX MONTHS. 4062 VACCING COUNS ELIMITED TO GUITS PER SIX MONTHS. 4063 VACCING COUNS ELIMITED TO SUNTS PER SIX MONTHS. 4064 VACCING COUNS ELIMITED TO SUNTS PER MEMBER, PER CALENDAR MEEK. 4069 PROCEDURE CODE IS LIMITED TO SUNTS, PER MEMBER, PER CALENDAR WEEK. 4069 PROCEDURE CODE IS LIMITED TO SUNTS, PER MEMBER, PER CALENDAR WEEK. 4069 PROCEDURE CODE IS LIMITED TO SUNTS, PER MEMBER, PER CALENDAR WEEK. 4070 SHARED LIVING SERVICES ARE LIMITED TO SEGO.00 PER CALENDAR MONTH PER SIX LIMITED SEGO.00 PER CALENDAR MEEK. 4081 PROCEDURE CODE IS LIMITED TO SUNTS, PER MEMBER, PER CALENDAR WEEK. 4082 PROCEDURE CODE IS LIMITED TO SUNTS, PER MEMBER, PER CALENDAR WEEK. 4084 PROCEDURE CODE IS LIMITED TO SUNTS, PER MEMBER, PER CALENDAR WEEK. 4084 PROCEDURE CODE IS LIMITED TO SUNTS, PER MEMBER, PER CALENDAR WEEK. 4085 PROCEDURE CODE IS LIMITED TO SUNTS, PER MEMBER, PER CALENDAR WEEK. 4086 PROCEDURE CODE IS LIMITED TO SUNTS, PER MEMBER, PER CALENDAR WEEK. 4086 PROCEDURE CODE IS LIMITED TO SUNTS, PER MEMBER, PER CALENDAR WEEK. 4087 PROCEDURE CODE IS LI	-	
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VACCINE COUNSELING PROCEDURE CODE 9940. IS LIMITED TO 4 PER MEMBER, PER CALENDAR WEEK.	6401	THIS SERVICE IS LIMITED TO 6 UNITS PER SIX MONTHS.
VACCINE COUNSELING PROCEDURE CODE 9940. IS LIMITED TO 4 PER MEMBER, PER CALENDAR WEEK.	6402	VACCIN CO UN SELING PROCEDURE CODE 99401 IS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER DATE OF SERVICE.
SHARED LIVING SERVICES ARE LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. SHARED LIVING SERVICES ARE LIMITED TO \$660.00 PER CALENDAR MONTH FOR SCI2 MEMBERS. SHARED LIVING SERVICES ARE LIMITED TO \$7560.00 PER CALENDAR MONTH FOR SCI2 MEMBERS. SHARED LIVING SERVICES ARE LIMITED TO \$2 UNITS, PER MEMBER, PER CALENDAR WEEK. SHARED PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. SHARED PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. SHARED PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. SHARED PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. SHARED PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR WEEK. SHARED PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR WEEK. SHARED PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR WEEK. SHARED PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR YEAR. SHARED PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR YEAR. SHARED PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR YEAR. SHARED PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR YEAR. SHARED PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR YEAR. SHARED PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR YEAR. SHARED PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR YEAR. SHARED PROCEDURE CODE DE248 IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR YEAR. SHARED PROCEDURE CODE DE248 IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR YEAR PER MEMBER. PRIOR AUTHORIZATION NEW PRIOR PR	6403	
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PROCEDURE CODE 87529 IS LIMITED TO TWO (2) UNITS PER DAY PER MEMBER. PROCEDURE CODES E0443 AND E0444 ARE LIMITED CUMULATIVELY TO ONE UNIT PER MONTH, PER MEMBER. PROCEDURE CODE A9274 IS LIMITED TO 12 UNITS PER CALENDAR MONTH, PER MEMBER. REVENUE CODE 905 IS LIMITED TO ONE UNIT PER DAY, PER MEMBER. PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER. MAXIMUM DOSAGES ALLOWED FOR PROCEDURE CODE S0190 PER DAY PER MEMBER HAS BEEN EXCEEDED. PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER. PROCEDURE CODE J2350 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER. PROCEDURE CODE J2350 IS LIMITED TO 600 UNITS/MGS PER DAY PER MEMBER. PROCEDURE CODE IS LIMITED TO ONE UNIT PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 49 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE A9277 IS LIMITED TO 36 UNITS PER MEMBER PER PROVIDER. PROCEDURE CODE A9277 IS LIMITED TO FOUR UNITS PER MEMBER PER CALENDAR YEAR. PROCEDURE CODE IS LIMITED TO 30 PER MEMBER PER CALENDAR YEAR. PROCEDURE CODE IS LIMITED TO 30 PER MEMBER PER CALENDAR YEARS TIME PERIOD.	6520	PHYSICAL THERAPY SERVICES EXCEED THE 30 VISITS ALLOWED PER CALENDAR YEAR PER MEMBER. PRIOR AUTHORIZATION
PROCEDURE CODES E0443 AND E0444 ARE LIMITED CUMULATIVELY TO ONE UNIT PER MONTH, PER MEMBER. PROCEDURE CODE A9274 IS LIMITED TO 12 UNITS PER CALENDAR MONTH, PER MEMBER. REVENUE CODE 905 IS LIMITED TO ONE UNIT PER DAY, PER MEMBER. PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER. MAXIMUM DOSAGES ALLOWED FOR PROCEDURE CODE S0190 PER DAY PER MEMBER HAS BEEN EXCEEDED. PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER HAS BEEN EXCEEDED. PROCEDURE CODE J2350 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER. PROCEDURE CODE J2350 IS LIMITED TO 600 UNITS/MGS PER DAY PER MEMBER. PROCEDURE CODE IS LIMITED TO ONE UNIT PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 49 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. H0038HQ LIMITED TO 8 UNITS PER DATE OF SERVICE PER MEMBER PER PROVIDER. PROCEDURE CODE A9277 IS LIMITED TO FOUR UNITS PER MEMBER PER CALENDAR YEAR. HOSPITAL RESERVE DAYS LIMITED TO 30 PER MEMBER PER CALENDAR YEAR. PROCEDURE CODE IS LIMITED TO ONE PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD. PROCEDURE CODE IS LIMITED TO \$6000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.	6521	SPEECH THERAPY SERVICES EXCEED THE 30 VISITS ALLOWED PER CALENDAR YEAR PER MEMBER. PRIOR AUTHORIZATION REQUIRED.
PROCEDURE CODE A9274 IS LIMITED TO 12 UNITS PER CALENDAR MONTH, PER MEMBER. REVENUE CODE 905 IS LIMITED TO ONE UNIT PER DAY, PER MEMBER. PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER. MAXIMUM DOSAGES ALLOWED FOR PROCEDURE CODE S0190 PER DAY PER MEMBER HAS BEEN EXCEEDED. PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER. PROCEDURE CODE J2350 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER. PROCEDURE CODE IS LIMITED TO 000 UNITS/MGS PER DAY PER MEMBER. PROCEDURE CODE IS LIMITED TO ONE UNIT PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 49 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. H0038HQ LIMITED TO 8 UNITS PER DATE OF SERVICE PER MEMBER PER PROVIDER. PROCEDURE CODE A9277 IS LIMITED TO FOUR UNITS PER MEMBER PER CALENDAR YEAR. HOSPITAL RESERVE DAYS LIMITED TO 30 PER MEMBER PER CALENDAR YEAR. PROCEDURE CODE IS LIMITED TO 95000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.	6522	PROCEDURE CODE 87529 IS LIMITED TO TWO (2) UNITS PER DAY PER MEMBER.
REVENUE CODE 905 IS LIMITED TO ONE UNIT PER DAY, PER MEMBER. 6526 PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER. 6527 MAXIMUM DOSAGES ALLOWED FOR PROCEDURE CODE S0190 PER DAY PER MEMBER HAS BEEN EXCEEDED. 6528 PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER. 6529 PROCEDURE CODE J2350 IS LIMITED TO 600 UNITS/MGS PER DAY PER MEMBER. 6530 PROCEDURE CODE IS LIMITED TO ONE UNIT PER MEMBER IN A 365 DAY TIME PERIOD. 6531 PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 49 DAY TIME PERIOD. 6532 PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. 6533 H0038HQ LIMITED TO 8 UNITS PER DATE OF SERVICE PER MEMBER PER PROVIDER. 6536 PROCEDURE CODE A9277 IS LIMITED TO FOUR UNITS PER MEMBER PER CALENDAR YEAR. 6539 PROCEDURE CODE IS LIMITED TO 30 PER MEMBER PER CALENDAR YEAR. 6540 PROCEDURE CODE IS LIMITED TO \$6000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.	6523	PROCEDURE CODES E0443 AND E0444 ARE LIMITED CUMULATIVELY TO ONE UNIT PER MONTH,PER MEMBER.
PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER. MAXIMUM DOSAGES ALLOWED FOR PROCEDURE CODE S0190 PER DAY PER MEMBER HAS BEEN EXCEEDED. PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER. PROCEDURE CODE J2350 IS LIMITED TO 600 UNITS/MGS PER DAY PER MEMBER. PROCEDURE CODE IS LIMITED TO ONE UNIT PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 49 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 49277 IS LIMITED TO FOUR UNITS PER MEMBER PER PROVIDER. PROCEDURE CODE A9277 IS LIMITED TO FOUR UNITS PER MEMBER PER CALENDAR YEAR. HOSPITAL RESERVE DAYS LIMITED TO 30 PER MEMBER PER CALENDAR YEAR. PROCEDURE CODE IS LIMITED TO ONE PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD. PROCEDURE CODE IS LIMITED TO \$6000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.	6524	PROCEDURE CODE A9274 IS LIMITED TO 12 UNITS PER CALENDAR MONTH, PER MEMBER.
MAXIMUM DOSAGES ALLOWED FOR PROCEDURE CODE S0190 PER DAY PER MEMBER HAS BEEN EXCEEDED. PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER. PROCEDURE CODE J2350 IS LIMITED TO 600 UNITS/MGS PER DAY PER MEMBER. PROCEDURE CODE IS LIMITED TO ONE UNIT PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 49 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER PER PROVIDER. PROCEDURE CODE A9277 IS LIMITED TO FOUR UNITS PER MEMBER PER CALENDAR YEAR. HOSPITAL RESERVE DAYS LIMITED TO 30 PER MEMBER PER CALENDAR YEAR. PROCEDURE CODE IS LIMITED TO ONE PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD. PROCEDURE CODE IS LIMITED TO \$6000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.	6525	REVENUE CODE 905 IS LIMITED TO ONE UNIT PER DAY, PER MEMBER.
PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER. PROCEDURE CODE J2350 IS LIMITED TO 600 UNITS/MGS PER DAY PER MEMBER. PROCEDURE CODE IS LIMITED TO ONE UNIT PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 49 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER PER PROVIDER. PROCEDURE CODE A9277 IS LIMITED TO FOUR UNITS PER MEMBER PER CALENDAR YEAR. HOSPITAL RESERVE DAYS LIMITED TO 30 PER MEMBER PER CALENDAR YEAR. PROCEDURE CODE IS LIMITED TO ONE PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD. PROCEDURE CODE IS LIMITED TO \$6000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.	6526	PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER.
PROCEDURE CODE J2350 IS LIMITED TO 600 UNITS/MGS PER DAY PER MEMBER. PROCEDURE CODE IS LIMITED TO ONE UNIT PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 49 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 49277 IS LIMITED TO 50 UNITS PER MEMBER PER PROVIDER. PROCEDURE CODE A9277 IS LIMITED TO FOUR UNITS PER MEMBER PER CALENDAR YEAR. HOSPITAL RESERVE DAYS LIMITED TO 30 PER MEMBER PER CALENDAR YEAR. PROCEDURE CODE IS LIMITED TO ONE PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD. PROCEDURE CODE IS LIMITED TO \$6000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.	6527	MAXIMUM DOSAGES ALLOWED FOR PROCEDURE CODE S0190 PER DAY PER MEMBER HAS BEEN EXCEEDED.
PROCEDURE CODE IS LIMITED TO ONE UNIT PER MEMBER IN A 365 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 49 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. H0038HQ LIMITED TO 8 UNITS PER DATE OF SERVICE PER MEMBER PER PROVIDER. PROCEDURE CODE A9277 IS LIMITED TO FOUR UNITS PER MEMBER PER CALENDAR YEAR. HOSPITAL RESERVE DAYS LIMITED TO 30 PER MEMBER PER CALENDAR YEAR. PROCEDURE CODE IS LIMITED TO ONE PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD. PROCEDURE CODE IS LIMITED TO \$6000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.	6528	PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER.
PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 49 DAY TIME PERIOD. PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. H0038HQ LIMITED TO 8 UNITS PER DATE OF SERVICE PER MEMBER PER PROVIDER. PROCEDURE CODE A9277 IS LIMITED TO FOUR UNITS PER MEMBER PER CALENDAR YEAR. H0SPITAL RESERVE DAYS LIMITED TO 30 PER MEMBER PER CALENDAR YEAR. PROCEDURE CODE IS LIMITED TO ONE PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD. PROCEDURE CODE IS LIMITED TO \$6000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.	6529	PROCEDURE CODE J2350 IS LIMITED TO 600 UNITS/MGS PER DAY PER MEMBER.
PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. H0038HQ LIMITED TO 8 UNITS PER DATE OF SERVICE PER MEMBER PER PROVIDER. PROCEDURE CODE A9277 IS LIMITED TO FOUR UNITS PER MEMBER PER CALENDAR YEAR. HOSPITAL RESERVE DAYS LIMITED TO 30 PER MEMBER PER CALENDAR YEAR. PROCEDURE CODE IS LIMITED TO ONE PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD. PROCEDURE CODE IS LIMITED TO \$6000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.	6530	PROCEDURE CODE IS LIMITED TO ONE UNIT PER MEMBER IN A 365 DAY TIME PERIOD.
 H0038HQ LIMITED TO 8 UNITS PER DATE OF SERVICE PER MEMBER PER PROVIDER. PROCEDURE CODE A9277 IS LIMITED TO FOUR UNITS PER MEMBER PER CALENDAR YEAR. HOSPITAL RESERVE DAYS LIMITED TO 30 PER MEMBER PER CALENDAR YEAR. PROCEDURE CODE IS LIMITED TO ONE PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD. PROCEDURE CODE IS LIMITED TO \$6000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD. 	6531	PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 49 DAY TIME PERIOD.
6536 PROCEDURE CODE A9277 IS LIMITED TO FOUR UNITS PER MEMBER PER CALENDAR YEAR. 6538 HOSPITAL RESERVE DAYS LIMITED TO 30 PER MEMBER PER CALENDAR YEAR. 6539 PROCEDURE CODE IS LIMITED TO ONE PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD. 6540 PROCEDURE CODE IS LIMITED TO \$6000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.	6532	PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD.
6538 HOSPITAL RESERVE DAYS LIMITED TO 30 PER MEMBER PER CALENDAR YEAR. 6539 PROCEDURE CODE IS LIMITED TO ONE PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD. 6540 PROCEDURE CODE IS LIMITED TO \$6000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.	6533	H0038HQ LIMITED TO 8 UNITS PER DATE OF SERVICE PER MEMBER PER PROVIDER.
PROCEDURE CODE IS LIMITED TO ONE PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD. PROCEDURE CODE IS LIMITED TO \$6000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.	6536	PROCEDURE CODE A9277 IS LIMITED TO FOUR UNITS PER MEMBER PER CALENDAR YEAR.
6540 PROCEDURE CODE IS LIMITED TO \$6000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.	6538	HOSPITAL RESERVE DAYS LIMITED TO 30 PER MEMBER PER CALENDAR YEAR.
	6539	PROCEDURE CODE IS LIMITED TO ONE PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.
DENTAL PROCEDURE CODES D7961 AND D7962 ARE LIMITED CUMULATIVELY TO 4 UNITS PER DATE OF SERVICE, PER MEMBER.	6540	PROCEDURE CODE IS LIMITED TO \$6000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.
	6541	DENTAL PROCEDURE CODES D7961 AND D7962 ARE LIMITED CUMULATIVELY TO 4 UNITS PER DATE OF SERVICE, PER MEMBER.

EOR Codo	Description
6542	PURCHASE OF PROCEDURE CODE E0329 LIMITED TO ONE PER 5 CALENDAR YEARS, PER MEMBER.
6543	CLAIM/DETAIL DENIED. MONITORED PROCEDURE CODES ARE LIMITED TO ONE PER MEMBER, PER 5 YEARS.
6544	CLAIM/DETAIL DENIED. MONITORED PROCEDURE CODES ARE LIMITED TO ONE FER MEMBER, PER 4 YEARS.
6545	CLAIM/DETAIL DENIED. MONITORED TROCEDORE CODES ARE LIMITED TO ONE PER MEMBER, PER 2 YEARS.
6547	MEMBER IS LIMITED TO ONE HUMIDIFIER PURCHASE IN A TWO-YEAR TIME PERIOD.
6548	DETAIL DENIED BY DMS AFTER REVIEW OF SUBMITTED DOCUMENTATION.
6549	PROCEDURE CODE B4100 IS LIMITED TO 180 UNITS (OUNCES) PER CALENDAR MONTH UNLESSPA IS ON FILE FOR ADDITIONAL
6553	PROCEDURE CODE IS LIMITED TO 192 UNITS PER CALENDAR MONTH, PER MEMBER.
6554	WAIVER LIMIT FOR PHARMACY HAS BEEN REACHED
6555	COVID-19 IS LIMITED TO ONE PER DAY PER MEMBER.
6556	HEARING EVALUATION PROCEDURE CODE IS LIMITED TO 4 PER MEMBER PER CALENDAR YEAR.
6557	HEARING EVALUATION PROCEDURE CODES LIMITED TO 1 PER MEMBER PER CALENDAR YEAR
6558	HEARING FOLLOW UP PROCEDURE CODES LIMITED TO 1 PER MEMBER PER CALENDAR YEAR.
6559	HOME INFUSION THERAPY PROCEDURE CODES LIMITED TO ONE PER MEMBER PER DATE OF SERVICE.
6560	CLAIM/DETAIL DENIED. PROCEDURE CODE 92015 IS LIMITED TO ONE PER MEMBER PER YEAR.
6561	CLAIM/DETAIL DENIED. REPAIR AND REFITTING OF SPECTACLES IS LIMITED TO ONE PER MEMBER PER YEAR.
6562	CLAIM/DETAIL DENIED. REFAIR AND RETTTING OF SPECIACLES IS CHARLES TO ONE FER MEMBER PER PROVIDER, PER YEAR.
6565	CLAIM/DETAIL DENIED. ESTABLISHED OFFICE VISIT LIMITED TO TWO PER MEMBER PER PROVIDER, PER TEAR. CLAIM/DETAIL DENIED. EAR IMPRESSIONS LIMITED TO 6 PER CALENDAR YEAR, PER EAR
6566	CLAIM/DETAIL DENIED. EAR IMPRESSIONS LIMITED TO 6 PER CALENDAR TEAR, PER EAR CLAIM/DETAIL DENIED. HEARING AID BATTERIES LIMITED TO 12 PER CALENDAR YEAR, PEREAR.
6568	PROCEDURE CODE IS LIMITED TO TWO PER TOOTH PER LIFETIME
6569	D9110 ON SAME DOS AS OTHER PROCEDURE
6570	PROCEDURE CODE IS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 12 MONTHS
	PROCEDURE CODE IS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 12 MONTHS PROCEDURE CODE IS LIMITED TO ONE PER 12 MONTHS.
6571 6572	PROCEDURE CODE IS LIMITED TO ONE PER 12 MIONTHS. PROCEDURE CODE IS LIMITED TO ONE PER 2 YEARS
6573	
6574	PROCEDURE CODE IS LIMITED TO ONE PER QUADRANT PER 36 MONTHS PROCEDURE CODE IS LIMITED TO ONE PER TOOTH PER 5 YEARS
6575	PROCEDURE CODE IS LIMITED TO ONE PER TOOTH PER 5 TEARS PROCEDURE CODE IS LIMITED TO ONE PER 5 YEARS
6576	PROCEDURE IS LIMITED TO ONE PER 5 YEARS PROCEDURE IS LIMITED TO ONE PER 5 YEARS
6577	PROCEDURE IS LIMITED TO ONE PER 5 TEARS PROCEDURE IS LIMITED TO ONE PER 6 MONTHS PER MEMBER
6578	PROCEDURE IS LIMITED TO ONE PER AREA (TOOTH) PER LIFETIME
6579	PROCEDURE IS LIMITED TO ONE PER AREA (TOOTH) PER LIFETIME PROCEDURE IS LIMITED TO ONE PER TOOTH PER LIFETIME
6580	PROCEDURE IS LIMITED TO ONE PER TOOTH PER LIFETIME PROCEDURE IS LIMITED TO ONE PER SITE (QUADRANT) PER LIFETIME
6581	PROCEDURE IS LIMITED TO ONE PER TOOTH, PER QUADRANT, PER LIFETIME
6582	PROCEDURE IS LIMITED TO ONE PER 5 YEARS UNLESS PA IS ON FILE FOR ANY ADDITIONALSERVICES THAT ARE DEEMED MEDICALLY
6584	PROCEDURE IS LIMITED TO ONCE EVERY 5 YEARS PROCEDURE IS LIMITED TO ONCE EVERY 5 YEARS
6585	PROCEDURE IS LIMITED TO TWO PER MEMBER PER 12 MONTHS
6586	PROCEDURE IS LIMITED TO ONE SET PER MEMBER, PER PROVIDER PER 12 MONTHS
6587	PROCEDURE CODE IS LIMITED TO GNE SETTER MEMBER, FERTROVIDER FER 12 MONTHS PROCEDURE CODE IS LIMITED TO 180 UNITS PER CALENDAR MONTH, PER MEMBER.
6588	PROCEDURE CODE IS LIMITED TO 150 UNITS PER CALENDAR MONTH, PER MEMBER.
6589	PROCEDURE IS NOT TO EXCEED THREE REPAIRS PER 12 MONTHS
6590	PROCEDURE IS LIMITED TO ONCE PER TOOTH, PER MEMBER, PER 12 MONTHS
6591	PROCEDURE IS LIMITED TO ONCE PER 100111, PER MEMBER, PER 12 MONTHS PROCEDURE IS LIMITED TO ONE PER 6 MONTHS
6592	CLAIM/DETAIL DENIED. D0120 IS LIMITED TO ONE PER 6 MONTHS.
6593	PROCEDURE IS LIMITED TO ONE PER 6 MONTHS, PER MEMBER, PER PROVIDER
6594	PROCEDURE IS LIMITED TO ONE PER 12 MONTHS
6598	CLAIM/DETAIL DENIED. PROCEDURE CODE E0483 IS LIMITED TO 3 CONSECUTIVE MONTHS RENTAL.
6600	CLAIM/DETAIL DENIED. PROCEDURE CODE E0485 IS CHAITED TO 3 CONSECUTIVE MONTHS RENTAL. CLAIM/DETAIL DENIED. E0483 IS LIMITED TO 3 MONTHS OF RENTAL PER 12 MONTH PERIOD.
6602	PROCEDURE CODE IS LIMITED TO 5 MONTHS OF RENTAL PER 12 MONTH PERIOD. PROCEDURE CODE IS LIMITED TO 6 UNITS PER CALENDAR YEAR, PER MEMBER.
6603	PROCEDURE CODE IS LIMITED TO 8 UNITS PER CALENDAR YEAR, PER MEMBER PROCEDURE CODE IS LIMITED TO 2 UNITS PER CALENDAR MONTH, PER MEMBER
6604	PROCEDURE CODE 13 LIMITED TO 2 UNITS PER CALENDAR MONTH, PER MEMBER PROCEDURE CODE E0271 IS LIMITED TO 1 PER MEMBER, PER CALENDAR YEAR.
6605	PROCEDURE IS LIMITED TO 2 PER CALENDAR YEAR UNLESS PA IS ON FILE FOR ANY ADDITIONAL SERVICES THAT ARE DEEMED
6660	THERAPEUTIC LEAVE DAYS GREATER THAN 14 CANNOT BE BILLED.
6661	PROFESSIONAL AND TECHNICAL COMPONENTS OF SERVICES ARE NOT PAYABLE WHEN THE COMPREHENSIVE SERVICE HAS BEEN
6700	FOLLOW-UP VISITS NOT PAYABLE WITHIN 10 DAYS OF SURGICAL PROCEDURE
	FOLLOW-UP VISITS NOT PAYABLE WITHIN 10 DAYS OF SURGICAL PROCEDURE FOLLOW-UP VISITS NOT PAYABLE WITHIN 30 DAYS OF SURGICAL PROCEDURE
6701	

FOR Code	Description
6702	FOLLOW-UP VISITS NOT PAYABLE WITHIN 45 DAYS OF SURGICAL PROCEDURE
6703	FOLLOW-UP VISITS NOT PAYABLE WITHIN 45 DAYS OF SURGICAL PROCEDURE
6704	FOLLOW-UP VISITS NOT PAYABLE WITHIN 90 DAYS OF SURGICAL PROCEDURE
6726	DENTAL PROPHY/FLUORIDE LIMITED TO 2 PER 351 DAYS
6737	CLAIM/DETAIL PAYMENT REDUCED. HEARING AIDS ARE LIMITED TO \$800.00 PER EAR
6742	PROCEDURE CODE D1206 IS LIMITED TO ONE UNIT PER 90 DAYS.
6743	PROCEDURE CODE D1206 IS LIMITED TO GNE CIVITY ER 90 DATS. PROCEDURE CODE D1206 IS LIMITED TO TWO UNITS PER YEAR.
6744	THIS SERVICE IS LIMITED TO 64 UNITS PER DAY OR IN COMBINATION WITH OTHER SELECTED PROCEDURE CODES
6745	CLAIM DENIED. MEMBER LIMITED TO 2 DIAGNOSTIC ULTRASOUNDS PER 9 MONTHS. MEDICALNECESSITY MUST SUPPORT UNUSUAL
0743	CIRCUMSTANCES. DIAGNOSIS CODE MUST INDICATE MEDIC
6746	THIS PROCEDURE LIMITED TO 1 PER MEMBER PER FOUR YRS
6748	DENTAL VISITS ARE LIMITED TO 12 PER CALENDAR YEAR FOR MEMBERS 21 YEARS OF AGE AND OLDER (PER PROVIDER).
6749	S5100 LIMITED TO 24 UNITS PER CALENDAR DAY
6750	S5100 LIMITED TO 24 ONTS PER CALENDAR DAT S5100 LIMITED TO 120 UNITS PER CALENDAR WEEK
6753	
	ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO TWO PER CALENDAR YEAR. REIMBURSEMENT CUT BACK TO RATE FOR
6754	PROCEDURE CODE H0040 IS LIMITED TO ONE PER CALENDAR MONTH PER MEMBER.
6755	CLAIM/DETAIL DENIED. MAXIMUM OF 30 HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER CALENDAR YEAR.
6760	MEMBER'S THERAPY SERVICES EXCEED THE 20 VISITS ALLOWED PER CALENDAR YEAR. PRIOR AUTHORIZATION REQUIRED.
6764	PROCEDURE CODE LIMITED TO 1 PER 12 MONTHS PER MEMBER, PER PROVIDER
6765	INITIAL VISIT LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS
6766	MAXIMUM OF 15 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER.
6767	PROCEDURE CODE LIMITED 2/TOOTH/LIFETIME/MEMBER
6770	EXTRACTIONS LIMITED TO 3 PER LIFETIME PER TOOTH.
6772	DETAIL DENIED. ONLY ONE EVALUATION AND MANAGEMENT PROCEDURE CODE ALLOWED PER DATE OF SERVICE.
6773	ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO TWO PER CALENDAR YEAR. REIMBURSEMENT CUT BACK TO RATE FOR
6774	PURCHASE LIMITED TO 1 PER 5 YEARS
6785	PROC CODE WEEKLY FREQUENCY ON PA HAS BEEN EXCEEDED
6786	PROC CODE MONTHLY FREQUENCY ON PA EXCEEDS
6787	REV CODE MONTHLY FREQUENCY ON PA HAS BEEN EXCEEDED
6788	REVENUE CODE 182 IS LIMITED TO A MAXIMUM OF 15 CONSECUTIVE DAYS
6789	REVENUE CODE 189 LIMITED TO 45 DAYS PER LIFETIME
6790	PROCEDURE CODE WEEKLY FREQUENCY ON PA HAS BEEN EXCEEDED.
6791	PROCEDURE CODE MONTHLY FREQUENCY ON PA HAS BEEN EXCEEDED.
6792	PROCEDURE CODE WEEKLY FREQUENCY ON PRIOR AUTHORIZATION HAS BEEN EXCEEDED.
6793	PROCEDURE CODE MONTHLY FREQUENCY ON PRIOR AUTHORIZATION HAS BEEN EXCEEDED.
6794	PROCEDURE CODE T1000 IS LIMITED TO NINETY-SIX (96) UNITS PER DAY, PER MEMBER, SAME OR DIFFERENT PROVIDER.
6795	PROCEDURE CODE T1000 IS LIMITED TO 8,000 UNITS (2000 HOURS) PER TWELVE (12) MONTH PERIOD, PER MEMBER, SAME OR
6796	PROCEDURE CODES 76700, 76705, 76770, 76775, AND G0389 ARE LIMITED TO 1 UNIT, CUMULATIVELY, PER CALENDAR YEAR, PER
6797	PROCEDURE CODES 77052, 77055, 77056, 77057, G0202, G0204, AND G0206 ARE LIMITEDTO 1 UNIT, CUMULATIVELY, PER CALENDAR
6798	PROCEDURE CODES 80422, 82947-82948, 82950-82953, AND 83036 ARE LIMITED TO 1 UNIT CUMULATIVELY, PER CALENDAR YEAR,
6799	PROCEDURE CODES 87590-87592, 87850, 87800, 87081, 87210, 87070, AND 87077 ARE LIMITED TO 1 UNIT, CUMULATIVELY, PER
6800	PROCEDURE CODES 86701-86703, 86689, AND 87390-87391 ARE LIMITED TO 1 UNIT, CUMULATIVELY, PER CALENDAR YEAR, PER
6801	PROCEDURE CODES 76977, 77078-77082, 78350-78351 AND G0130 ARE LIMITED TO 1 UNIT, CUMULATIVELY, PER CALENDAR YEAR,
6802	REVENUE CODE 180 IS LIMITED TO 5 UNITS PER CALENDAR YEAR FOR PRTF AND PRTF 2 CLAIMS.
6803	REVENUE CODE 183 IS LIMITED TO 14 UNITS PER CALENDAR YEAR FOR PRTF AND PRTF 2 CLAIMS.
6804	THIS PROCEDURE CODE IS LIMITED TO 1 UNIT EACH PER MEMBER, PER DATE OF SERVICE.
6805	H0035, H0015, AND S9480 ARE LIMITED TO 1 UNIT EACH PER MEMBER, PER DATE OF SERVICE.
6806	97003 AND 97004 NOT ALLOWED ON THE SAME DATE OF SERVICE.
6807	OCCUPATIONAL THERAPY IS LIMITED TO 20 VISITS PER MEMBER, PER CALENDAR YEAR.
6808	H0040 IS LIMITED TO 1 UNIT PER CALENDAR MONTH PER MEMBER.
6809	V2020 IS LIMITED TO ONE UNIT PER CALENDAR YEAR.
6810	EYEWARE CODES V2100 THRU V2499, V2500 THRU V2522, V2524 THRU V2531, AND V2700 THRU V2784 ARE LIMITED TO 2 UNITS
6811	T2023 LIMITED TO 1 UNIT PER CALENDAR MONTH.
6812	PROCEDURE CODE A4606 LIMITED TO 4 PER CALENDAR MONTH.
6813	PROCEDURE CODE E0602 IS LIMITED TO ONE PER CALENDAR YEAR.

EOB Code	Description
6814	PROCEDURE CODES 77052, 77055, 77056, 77057, G0202, G0204, AND G0206 ARE LIMITEDTO 1 UNIT, CUMULATIVELY, PER CALENDAR
6815	THIS PROCEDURE CODE MUST BE BILLED IN CONJUNCTION WITH 90837.
6816	99355 IS LIMITED TO TWO UNITS PER DATE OF SERVICE, PER MEMBER.
6817	PROCEDURE CODE 99355 MUST BE BILLED IN CONJUNCTION WITH PROCEDURE CODE 99354.
6818	THIS PROCEDURE CODE IS LIMITED TO 1 UNIT OF SERVICE PER DATE OF SERVICE, PER MEMBER, PER PROVIDER.
6819	AIR AMBULANCE PROCEDURE CODES ARE ALL-INCLUSIVE AND CANNOT BE BILLED WITH OTHERPROCEDURE CODES FOR THE SAME
6820	REVENUE CODES 551 AND 561 ARE LIMITED TO A TOTAL OF 16 UNITS (4 HOURS), CUMULATIVELY, PER DATE OF SERVICE, PER
6821	PROCEDURE CODE V2523 (CONTACT LENS) IS LIMITED TO 16 UNITS PER MEMBER, PER CALENDAR YEAR.
6822	CERTAIN PROCEDURE CODES ARE NOT PAYABLE WITHIN THE SAME CALENDAR WEEK AS H0020 OR H0047.
6823	THIS PROCEDURE CODE IS LIMITED TO ONE UNIT PER CALENDAR WEEK.
6824	THIS PROCEDURE CODE IS LIMITED TO 4 UNITS PER CALENDAR YEAR.
6825	EYEWARE CODES V2100 THRU V2499, V2500 THRU V2522, AND V2524 THRU V2531, ARE LIMITED TO 4 UNITS (CUMULATIVELY) PER
6826	LENS ADD-ON CODES LIMITED UP TO 4 EACH PER CALENDAR YEAR.
6827	PROCEDURE CODE S9484 IS LIMITED TO 23 UNITS PER DATE OF SERVICE.
6828	PROCEDURE CODE S9485 IS LIMITED TO ONE UNIT PER DATE OF SERVICE.
6829	PROCEDURE CODE H0018 IS LIMITED TO ONE UNIT PER DATE OF SERVICE FOR PROVIDER TYPES 26 AND 30.
7000	CLAIM FAILED A PRODUR ALERT
7001	CLAIM GENERATED AN INFORMATIONAL PRODUR ALERT
7002	DENIED FOR PRODUR REASONS
7020	UNABLE TO DETERMINE THE COINS AND DED, RESUBMIT ON PAPER WITH EOMB
7200	MISCELLANEOUS CLAIMSXTEN ERROR.
7201	PROCEDURE IS A NEWBORN PROCEDURE; AGE SHOULD BE LESS THAN 1 YEAR
7202	PROCEDURE IS A PEDIATRIC PROCEDURE; AGE SHOULD BE 1-17 YEARS
7203	PROCEDURE IS A MATERNITY PROCEDURE; AGE SHOULD BE 12-55 YEARS
7204	PROCEDURE IS AN ADULT PROCEDURE; AGE SHOULD BE OVER 14 YEARS
7205	PROCEDURE IS NOT INDICATED FOR A MALE
7206	PROCEDURE IS NOT INDICATED FOR A FEMALE
7207	PROCEDURE IS CLASSIFIED AS A COSMETIC PROCEDURE
7208	PROCEDURE IS AN UNLISTED PROCEDURE
7209	PROCEDURE IS CLASSIFIED AS EXPERIMENTAL
7210	PROCEDURE IS CLASSIFIED AS OBSOLETE
7211	SUBMITTED PROCEDURE IS INVALID FOR MEMBER'S AGE.
7212	SUBMITTED PROCEDURE CODE HAS BEEN REPLACED WITH A CODE MORE APPROPRIATE FOR THEMEMBER'S AGE.
7213	SUBMITTED PROCEDURE IS INVALID FOR MEMBER'S GENDER.
7214	SUBMITTED PROCEDURE CODE HAS BEEN REPLACED WITH A CODE MORE APPROPRIATE FOR THEMEMBER'S GENDER.
7215	PROCEDURE CODE IS INCIDENTAL
7216	VISIT PROCEDURE CODE IS NOT INDICATED FOR SEPARATE REIMBURSEMENT
7217	PROCEDURE CODE HAS BEEN REBUNDLED
7218	PROCEDURE ADDED DUE TO REBUNDLING.
7219	PROCEDURE IS MUTUALLY EXCLUSIVE
7220	PROCEDURE IS WITHIN THE NUMBER OF DAYS PRE-OP RANGE
7221	PROCEDURE IS WITHIN THE NUMBER OF DAYS POST-OP RANGE
7222	PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON
7223	PROCEDURE MAY NOT REQUIRE AN ASSISTANT SURGEON
7233	DUPLICATE DENIED - INCLUDES UNILATERAL OR BILATERAL
7234	DENIED DUPLICATE - IS BILATERAL
7235	DENIED DUPLICATE - CAN ONLY BE DONE XX TIMES IN LIFETIME
7236	DENIED DUPLICATE - CAN ONLY BE DONE XX TIMES IN A DAY
7237	DENIED DUPLICATE (REBUNDLED)
7238	PROCEDURE ADDED DUE TO DUPLICATE REBUNDLING
7239	PROCEDURE IS A POSSIBLE DUPLICATE
7240	SMARTSUSPENSE SUSPEND
7241	SMARTSUSPENSE DENIAL
7242	DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE DENIED
7243	DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE SUSPENDED

EOB Code	Description
7244	MEDICAL VISIT DENIED
7245	PROCEDURE ADDED DUE TO NEW VISIT FREQUENCY CODE REPLACEMENT
7246	PROCEDURE REPLACED DUE TO INTENSITY OF SERVICE REPLACEMENT
7247	PROCEDURE ADDED DUE TO INTENSITY OF SERVICE REPLACEMENT
7248	INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS
7249	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT
7250	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT
7251	PROCEDURE IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR
7252	DIAGNOSIS 1 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC
7253	DIAGNOSIS 2 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC
7254	DIAGNOSIS 3 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC
7255	DIAGNOSIS 4 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC
7256	MODIFIER 51 INVALID FOR PRIMARY PROCEDURE
7257	MODIFIER 51 MISSING FOR NON-PRIMARY PROCEDURE
7258	REVIEW MODIFIER 51
7259	SPLIT DECISION WAS RENDERED ON EXPANSION OF UNITS
7260	MORE THAN 100 LINES WERE ELIGIBLE FOR CLAIMCHECK PROCESSING
7261	INVALID PROCEDURE CODE
7262	DOB CANNOT BE GREATER THAN DATE OF SERVICE
7263	DOS REQUIRED FOR PROCEDURE
7264	DOS CANNOT BE A FUTURE DATE
7265	BIRTHDATE CANNOT BE A FUTURE DATE
7266	AGE CANNOT BE GREATER THAN 124 YEARS
7267	ONLY ONE PROVIDER ALLOWED FOR CURRENT PROCEDURES
7268	PROVIDER IS REQUIRED FOR HISTORY PROCEDURES
7269	MODIFIER NOT VALID FOR THIS PROCEDURE
7270	INVALID MODIFIER/PROCEDURE CODE COMBINATION
7271	CURRENT PROCEDURE LINES MUST HAVE SAME PROVIDER ID
7272	DIAGNOSIS 1 MUST BE A VALID CODE
7273	DIAGNOSIS 2 MUST BE A VALID CODE
7274	DIAGNOSIS 3 MUST BE A VALID CODE
7275	DIAGNOSIS 4 MUST BE A VALID CODE
7276	DIAGNOSIS MUST BE A VALID CODE
7277	PROCEDURE LINE DIAGNOSIS MUST BE A VALID CODE
7278	INVALID DATE (DATE OF BIRTH)
7279	INVALID AMOUNT CHARGED
7280	CLAIM LEVEL PROVIDER OR PROCEDURE LINE PROVIDER IS REQUIRED
7281	DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE
7282	INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS
7283	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT
7284	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT
7285	PROCEDURE IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR
7286	DIAGNOSIS IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR
7287	DIAGNOSIS IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR
7288	SMARTSUSPENSE FLAG
7289	SMARTSUSPENSE MONITOR
7290	MODIFIER 51 DELETED FOR PRIMARY PROCEDURE
7291	MODIFIER 51 ADDED FOR NON-PRIMARY PROCEDURE
7292	CLAIM/DETAIL DENIED. PROCEDURE IS NCCI INCIDENTAL/MUTUALLY EXCLUSIVE.
7293	CLAIM/DETAIL DENIED. PROCEDURE CODE IS CCI MUTUALLY EXCLUSIVE.
7499	MEMBER LOCK-IN TO SPECIFIC PRESCRIBING PROVIDER
7500	YOUR CLAIM IS BEING REVIEWED
7501	YOUR CLAIM IS BEING REVIEWED.
7502	MEMBER LOCKED IN TO A SPECIFIC PROVIDER
7503	MISSING/INVALID PRODUR CONFLICT CODE. ALERT ON RESPONSE DOES NOT MATCH AN ALERT SET ON THE CLAIM. PLEASE USE

EOB Code	Description
7504	MISSING/INVALID PRODUR INTERVENTION CODE. PLEASE USE MO, PO OR RO AND RESUBMIT.
7505	MISSING/INVALID PRODUR OUTCOME CODE. PLEASE USE 1A-1G, 2A OR 2B.
7506	RESPONSE CLAIM. ORIGINAL CLAIM FAILED A NON-OVERRIDEABLE ALERT. CONTACT COLLEGE OF PHARMACY TO RECEIVE PRIOR
7507	VALID OUTCOME CODE OF "NOT FILLED" RECEIVED. RESPONSE ACCEPTED, CLAIM REJECTED.
7508	Quantity dispensed on response claim same as original claim
7509	RENDERING PROVIDER ON PREPAYMENT REVIEW
8000	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO BILLING ERROR.
8001	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO CHANGE IN OTHER.
8002	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO CHANGE IN MEDICARE.
8003	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO KEYING ERROR.
8004	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO PATIENT LIABILITY.
8005	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO SPENDDOWN.
8006	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO MISCELLANEOUS ERROR.
8007	PROVIDER REQUESTED CLAIM ADJUSTMENT DUE TO BILLING ERROR.
8008	PROVIDER REQUESTED CLAIM ADJUSTMENT DUE TO MISC. OR UNSPECIFIED ERROR
8019	PROVIDER REQUESTED A FULL OFFSET DUE TO A MISCELLANEOUS OR UNSPECIFIED ERROR.
8020	SURS INITIATED A FULL OFFSET DUE TO A DUPLICATE PAYMENT.
8021	SURS INITIATED A FULL OFFSET DUE TO WRONG PROVIDER.
8022	SURS INITIATED A FULL OFFSET DUE TO WRONG MEMBER NUMBER.
8023	SURS INITIATED A FULL OFFSET DUE TO WRONG NDC/PROCEDURE CODE/MODIFIER CODE
8024	SURS INITIATED A FULL OFFSET DUE TO WRONG UNITS OF SERVICE.
8025	SURS INITIATED A FULL OFFSET DUE TO WRONG PATIENT LIABILITY AMOUNT.
8026	SURS INITIATED A FULL OFFSET DUE TO PAYMENT IN FULL FROM ANOTHER INSURANCE.
8027	SURS INITIATED A FULL OFFSET DUE TO PAYMENT IN FULL FROM MEDICARE.
8028	SURS INITIATED A FULL OFFSET DUE TO WRONG DATE(S) OF SERVICE.
8030	PROVIDER REQUESTED OFFSET DUE TO BILLING ERROR.
8031	PROVIDER REQUESTED OFFSET DUE TO OTHER INSURANCE.
8032	PROVIDER REQUESTED OFFSET DUE MEDICARE.
8033	PROVIDER REQUESTED OFFSET DUE TO PATIENT LIABILITY.
8034	PROVIDER REQUESTED OFFSET DUE TO SPENDDOWN.
8035	PROVIDER REQUESTED OFFSET DUE TO AUTO LIABILITY.
8036	PROVIDER REQUESTED OFFSET DUE TO WORKERS COMP
8037	PROVIDER REQUESTED CLAIM VOID DUE TO BILLING ERROR.
8038	PROVIDER REQUESTED OFFSET DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR
8039	YOUR ADJUSTMENT REQUEST HAS RESULTED IN THE DENIAL AND RECOUPMENT OF THE CLAIM.PLEASE RESUBMIT YOUR ORIGINAL
8040	PROVIDER INITIATED INTERNET ADJUSTMENT
8041	ADJUSTMENT REQUEST DENIED. PLEASE CORRECT ERROR AND SUBMIT ANOTHER ADJUSTMENT-OR-SUBMIT ADJUSTMENT TO THE
8042	SAVE FOR FUTURE USE.
8043	SAVE FOR FUTURE USE.
8044	SAVE FOR FUTURE USE.
8045	SAVE FOR FUTURE USE.
8046	SAVE FOR FUTURE USE.
8047	SAVE FOR FUTURE USE.
8048	SAVE FOR FUTURE USE.
8049	SAVE FOR FUTURE USE.
8050	EXPENDITURE WARRANT VOID
8051	SAVE FOR FUTURE USE.
8052	SAVE FOR FUTURE USE.
8053	SAVE FOR FUTURE USE.
8054	SAVE FOR FUTURE USE.
8055	SAVE FOR FUTURE USE.
8056	SAVE FOR FUTURE USE.
8057	SAVE FOR FUTURE USE.
8058	SAVE FOR FUTURE USE.
8059	PROVIDER SENT A FULL REFUND DUE TO COST SETTLEMENT (REQ FYE)

EOR Code	Description
8060	PROVIDER SENT REFUND DUE TO BILLING ERROR.
8061	PROVIDER SENT REFUND DUE TO CLAIMS PROCESSING ERROR.
8062	PROVIDER SENT REFUND DUE TO DUPLICATE PAYMENT.
8063	PROVIDER SENT REFUND DUE TO MEMBER/RELATIVE PAID.
8064	PROVIDER SENT REFUND DUE TO MEDICARE PAID,
8065	PROVIDER SENT REFUND DUE TO CASUALTY INSURANCE PAID.
8066	PROVIDER SENT REFUND DUE TO HEALTH INSURANCE PAID.
8067	PROVIDER SENT REFUND DUE TO SURS REVIEW.
8068	PROVIDER SENT REFUND PAYMENT DUE TO SURS REVIEW.
8069	PROVIDER SENT REFUND DUE TO PAID WRONG VENDOR.
8070	PROVIDER SENT REFUND DUE TO MEDICAID FRAUD.
8071	PROVIDER SENT REFUND DUE TO MEDICAID TRAGE.
8072	PROVIDER SENT REFUND DUE TO AUTO INSURANCE PAID.
8073	PROVIDER SENT REFUND DUE TO WORKERS COMPENSATION PAID.
8074	PROVIDER SENT REFUND FOR ICN NOT IN HISTORY.
8075	PROVIDER SENT REFUND DUE TO MISCELLANEOUS OR OTHER UNSPECIFIED ERROR.
8076	PRV REFUND - OTHER TPL REASON
8077	PRV REFUND - PSYCH CROSSOVER
8079	SAVE FOR FUTURE USE.
8080	SAVE FOR FUTURE USE.
8081	SAVE FOR FUTURE USE.
8082	NON-CLAIM SPECIFIC REFUND DUE TO BILLING ERROR.
8083	NON-CLAIM SPECIFIC REFUND DUE TO OTHER INSURANCE.
8084	NON-CLAIM SPECIFIC REFUND DUE TO SURS.
8085	NON-CLAIM SPECIFIC REFUND DUE TO MISC OR UNSPECIFIED ERROR.
8086	SAVE FOR FUTURE USE.
8087	SAVE FOR FUTURE USE.
8088	SAVE FOR FUTURE USE.
8101	SAVE FOR FUTURE USE.
8102	SAVE FOR FUTURE USE.
8103	SAVE FOR FUTURE USE.
8104	SAVE FOR FUTURE USE.
8105	SAVE FOR FUTURE USE.
8106	SAVE FOR FUTURE USE.
8107	SAVE FOR FUTURE USE.
8135	EDS INITIATED OFFSET DUE TO PROCESSING ERROR
8136	INITIATED ADJUSTMENT DUE TO REVERSAL OF PREVIOUS PROCESSING OF RECOUP/CASH RECEIPT
8141	SAVE FOR FUTURE USE.
8142	SAVE FOR FUTURE USE.
8143	SAVE FOR FUTURE USE.
8144	SAVE FOR FUTURE USE.
8145	SAVE FOR FUTURE USE.
8146	SAVE FOR FUTURE USE.
8147	SAVE FOR FUTURE USE.
8148	SUPPLEMENTAL CLAIM VOID DUE TO ENCOUNTER VOID RECEIVED.
8149	ADJUSTMENT DUE TO SUPPLEMENTAL CLAIM PROCESSING.
8166	EDS INITIATED ADDITIONAL PAYMENT DUE TO PROCESSING ERROR.
8167	INITIATED ADJUSTMENT DUE TO REVERSAL PROCESSING OF RECOUP/CASH REFUND.
8179	YOUR VOID TRANSACTION HAS BEEN PROCESSED
8180	MASS ADJUSTMENT - INPATIENT HOSPITAL RATE CHANGE.
8181	MASS ADJUSTMENT - OUTPATIENT HOSPITAL RATE CHANGE
8182	MASS ADJUSTMENT- INDIAN HOSPITAL RATE CHANGE.
8183	MASS ADJUSTMENT - RURAL HEALTH CLINIC RATE CHANGE.
8184	MASS ADJUSTMENT - PROCEDURE CODE RATE CHANGE
8185	MASS ADJUSTMENT - RETROACTIVE RATE CHANGE.

COD Code	Description
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8186	MASS ADJUSTMENT PROVIDER BILLING ERROR (RATE CHANGE).
8187	OTHER REQUEST FOR MASS ADJUSTMENT
8188	VOID TRANSACTIONS - MASS ADJUSTMENT
8189	MASS ADJUSTMENT - VOID TRANSACTIONS - REFUND RECEIVED
8190	MASS ADJUSTMENT - VOID TRANSACTIONS - WARRANT CANCELLED
8191	MASS ADJUSTMENT - VOID TRANSACTIONS OTHER REQUEST
8192	CLAIM ADJUSTED PER LEWIN MODEL DRG RATES.
8199	SAVE FOR FUTURE USE.
8200	TPL PRIVATE HEALTH INSURANCE - CARRIER
	TPL PRIVATE HEALTH INSURANCE - PROVIDER
8202	TPL PRIVATE HEALTH INSURANCE - MEMBER
8203	AUTO LIABILITY - CARRIER
8204	AUTO LIABILITY - PROVIDER
8205	AUTO LIABILITY - MEMBER
8206	NON-AUTO LIABILITY - CARRIE
8207	NON-AUTO LIABILITY - PROVIDER
8208	NON-AUTO LIABILITY - MEMBER
8209	WORKER'S COMP - CARRIER
8210	WORKER'S COMP - PROVIDER
8211	WORKER'S COMP - MEMBER
8212	PROBATE'S ESTATE
8213	INCOME PENSION TRUST RECOVERIES
8214	VICTIM'S RESTITUTION
8215	ABSENT PARENTS
0213	ABSERT TAREETS
8216	TPL ERROR
8217	DUE TO MISCELLANEOUS OR UNSPECIFIED REASON
8220	SAVE FOR FUTURE USE * TEMPORARILY USE FOR VOIDS *
	SAVE FOR FUTURE USE.
8222	SAVE FOR FUTURE USE
8223	SAVE FOR FUTURE USE.
8224	SAVE FOR FUTURE USE.
8225	CAPITATION - DEATH OF MEMBER
8226	CAPITATION - DEATH OF MEMBER CAPITATION - MEMBER INCARCERATED
-	
8227	CAPITATION - EPSDT CLAIM
8228	CAPITATION - MEMBER ENROLLED IN ERROR
8229	CAPITATION - FAMILY PLANNING
8230	ICN VOIDED DUE TO WARRANT RETURN.
8231	CAPITATION - DEMOGRAPHIC CHANGE
8232	CAPITATION - OTHER
	SAVE FOR FUTURE USE.
8234	SAVE FOR FUTURE USE.
8240	ADJUSTMENT GENERATED DUE TO SURS REVIEW
8241	ADJUSTMENT GENERATED DUE TO CHANGE IN PATIENT LIABILITY
8242	ADJUSTMENT GENERATED DUE TO RATE CHANGE
8244	PAYOUT PROCESSED DUE TO DISPROPORTIONATE SHARE
8245	POINT OF SALE
8246	POINT OF SALE REVERSAL
8299	ADJUSTMENT TO CROSSOVER PAID PRIOR TO AIM IMPLEMENTATION DATE. THIS CLAIM HAS BEEN MANUALLY PRICED USING THE
8300	A PAYOUT HAS BEEN ESTABLISHED FOR THE PROVIDER. THE REIMBURSEMENT IS INCLUDED IN THE CHECKWRITE.
8301	A PAYOUT HAS BEEN ESTABLISHED FOR THE PROVIDER. THE REIMBURSEMENT HAS BEEN EXCLUDED FROM THE CHECKWRITE.
8302	A PAYOUT IS DUE TO THE PROVIDER AS A RESULT OF OVER REFUND. THE REIMBURSEMENT IS INCLUDED IN THE CHECKWRITE.
8303	A PAYOUT IS DUE TO THE PROVIDER AS A RESULT OF OVER PAYMENT. THE REIMBURSEMENTHAS BEEN EXCLUDED FROM THE
8304	PAYOUT DUE TO ADVANCE. PAYMENT INCLUDED IN CHECKWRITE.
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FOR Code	Description
8305	PAYOUT DUE TO ADVANCE. PAYMENT EXCLUDED FROM CHECKWRITE.
8306	CHECK RECEIVED BY EDS FOR CLAIM ADJUSTMENT ON A PREVIOUSLY ADJUSTED CLAIM. AMOUNT OF REFUND BEING RETURNED TO
8307	PAYOUT EXCLUDED FROM CHECKWRITE.
8308	PAYOUT DUE TO HOSPITAL SUPPLEMENTAL GME ADJUSTMENT
8309	PAYOUT DUE TO MANAGED CARE - RESIDENT PCP PAYMENT
8310	PAYOUT DUE TO MANAGED CARE - RESIDENT DELIVERY PAYMENT
8311	PAYOUT DUE TO MANAGED CARE - RESIDENT DELIVERY PAYMENT
8312	PAYOUT DUE TO MANAGED CARE - ABD RISK BASED FATM PAYOUT DUE TO MANAGED CARE - SP/ABD QUARTERLY PAYMENT
8313	PAYOUT DUE TO MANAGED CARE - STYABD QUARTERET FATMENT
8314	PAYOUT DUE TO MANAGED CARE - CUSTODY INDICATOR ERROR
8315	PAYOUT DUE TO MANAGED CARE - COSTODY INDICATOR ERROR PAYOUT DUE TO MANAGED CARE - ENROLLMENT ERROR
8316	PAYOUT DUE TO MANAGED CARE - ENROLLIMENT ERROR PAYOUT DUE TO MANAGED CARE - OTHER
8317	PAYOUT DUE TO MEDICAL AUTHORIZATION UNIT REVIEW -CCU
8318	PAYOUT DUE TO LONG TERM CARE FACILITY CERTIFICATION DATE ERROR
8319	PAYOUT DUE TO LONG TERM CARE FACILITY CERTIFICATION DATE ERROR PAYOUT DUE TO LONG TERM CARE FACILITY CLAIM PROCESSING ERROR
8320	
8321	PAYOUT DUE TO PATIENT LIABILITY ERROR PAYOUT DUE TO PATIENT SPENDDOWN ERROR
8322	PAYOUT DUE TO NON EMERCENCY TRANSPORTATION
8323	PAYOUT DUE TO CAS SUBSUARCE
8325	PAYOUT DUE TO GAS SURCHARGE.
8326	PAYOUT DUE TO CORRECTION TO ACCOUNTS RECEIVABLE PROCESSED.
8327	PAYOUT DUE TO DHS/DDSD SUPPORTED LIVING PROGRAM AUDIT.
8328	PAYOUT DUE TO DHS/DDSD AUDIT
8329	PAYOUT PROCESSED FROM STATE ONLY FUNDS
8330	PAYOUT DUE TO ELIGIBILITY NOT ON FILE.
8331	PAYOUT DUE TO CLAIM TOO OLD TO PROCESS
8332	PAYOUT DUE TO MISCELLANEOUS OR UNSPECIFIED REASON.
8336	RETROACTIVE INTEREST PAYMENT
12257	
8352	CAPITATION WARRANT VOID
8399	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED.
8399 8400	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS.
8399 8400 8401	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR
8399 8400 8401 8402	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8399 8400 8401 8402 8403	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR
8399 8400 8401 8402 8403 8404	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM
8399 8400 8401 8402 8403 8404 8405	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM DUE TO A LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8399 8400 8401 8402 8403 8404 8405 8406	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM DUE TO A LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR
8399 8400 8401 8402 8403 8404 8405 8406 8407	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM DUE TO A LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR RELEASE OF LIEN RECEIVED BY LIEN HOLDER
8399 8400 8401 8402 8403 8404 8405 8406 8407 8408	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM DUE TO A LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR RELEASE OF LIEN RECEIVED BY LIEN HOLDER DECREASE TO ORIGINAL LIEN AMOUNT.
8399 8400 8401 8402 8403 8404 8405 8406 8407 8408 8409	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM DUE TO A LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR RELEASE OF LIEN RECEIVED BY LIEN HOLDER DECREASE TO ORIGINAL LIEN AMOUNT. INCREASE TO ORIGINAL LIEN AMOUNT
8399 8400 8401 8402 8403 8404 8405 8406 8407 8408 8409 8410	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM DUE TO A LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR RELEASE OF LIEN RECEIVED BY LIEN HOLDER DECREASE TO ORIGINAL LIEN AMOUNT. INCREASE TO ORIGINAL LIEN AMOUNT SAVE FOR FUTURE USE
8399 8400 8401 8402 8403 8404 8405 8406 8407 8408 8409 8410	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM DUE TO A LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR RELEASE OF LIEN RECEIVED BY LIEN HOLDER DECREASE TO ORIGINAL LIEN AMOUNT. INCREASE TO ORIGINAL LIEN AMOUNT SAVE FOR FUTURE USE SAVE FOR FUTURE USE
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8399 8400 8401 8402 8403 8404 8405 8406 8407 8408 8409 8410 8411 8412 8413 8414 8415 8419	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO ALIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR RELEASE OF LIEN RECEIVED BY LIEN HOLDER DECREASE TO ORIGINAL LIEN AMOUNT. INCREASE TO ORIGINAL LIEN AMOUNT SAVE FOR FUTURE USE
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8399 8400 8401 8402 8403 8404 8405 8406 8407 8408 8409 8410 8411 8412 8413 8414 8415 8419 8420 8421 8422	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR RELEASE OF LIEN RECEIVED BY LIEN HOLDER DECREASE TO ORIGINAL LIEN AMOUNT. INCREASE TO ORIGINAL LIEN AMOUNT SAVE FOR FUTURE USE AS THE RESULT OF AN AUDIT DIVISION REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE AS THE RESULT OF AN AUDIT DIVISION REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE AS THE RESULT OF A COST SETTLEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE
8399 8400 8401 8402 8403 8404 8405 8406 8407 8408 8409 8410 8411 8412 8413 8414 8415 8419 8420 8421 8422 8423	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR RELEASE OF LIEN RECEIVED BY LIEN HOLDER DECREASE TO ORIGINAL LIEN AMOUNT. INCREASE TO ORIGINAL LIEN AMOUNT SAVE FOR FUTURE USE SAVE FOR FUTURE USE
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8399 8400 8401 8402 8403 8404 8405 8406 8407 8408 8409 8410 8411 8412 8413 8414 8415 8419 8420 8421 8422 8423 8424 8425	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO A GRANISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR RELEASE OF LIEN RECEIVED BY LIEN HOLDER DECREASE TO ORIGINAL LIEN AMOUNT. INCREASE TO ORIGINAL LIEN AMOUNT SAVE FOR FUTURE USE AS THE RESULT OF AN AUDIT DIVISION REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE AS THE RESULT OF AN AUDIT DIVISION REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE AS THE RESULT OF A COST SETTLEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE AS THE RESULT OF A COST SETTLEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/ODDO AUDIT. AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/ODDO AUDIT. AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/OHLD AUDIT.
8399 8400 8401 8402 8403 8404 8405 8406 8407 8408 8409 8410 8411 8412 8413 8414 8415 8419 8420 8421 8422 8423 8424	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO A GRANISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR DUE TO A LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR RELEASE OF LIEN RECEIVED BY LIEN HOLDER DECREASE TO ORIGINAL LIEN AMOUNT. INCREASE TO ORIGINAL LIEN AMOUNT SAVE FOR FUTURE USE AS THE RESULT OF AN AUDIT DIVISION REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE AS THE RESULT OF A COST SETTLEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE AS THE RESULT OF A COST SETTLEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/DDSD AUDIT. AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/CHILD WELFARE.

EOB Code	Description
	AS THE RESULT OF A FINANCIAL MANAGEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE
	AS THE RESULT OF A LEGAL SETTLEMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED
	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO LONG TERM CARE FACILITY CLAIM PROCESSING ERROR.
	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MANAGED CARE ADJUSTMENTS.
	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MEDICAID FRAUD.
8433	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MEDICAL DIVISION REVIEW.
8434	AS THE RESULT OF AN OFMQ REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM
	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PATIENT LIABILITY ERROR.
8436	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PATIENT SPENDDOWN ERROR.
8437	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PHARMACY DIVISION REVIEW.
8438	AS THE RESULT OF A SURS AUDIT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM
8439	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO THIRD PARTY LIABILITY.
8440	SAVE FOR FUTURE USE.
8441	CLAIM GENERATED DUE TO ICN ON AR ROLLUP AND PARTIAL RECOUPMENT/REFUND APPLIED TO OFFSET.
8442	SAVE FOR FUTURE USE.
8443	SAVE FOR FUTURE USE.
8444	SAVE FOR FUTURE USE.
8445	SAVE FOR FUTURE USE.
8446	SAVE FOR FUTURE USE.
8447	SAVE FOR FUTURE USE.
8448	SAVE FOR FUTURE USE.
8449	SAVE FOR FUTURE USE.
8450	THIS ACCOUNT RECEIVABLE HAS BEEN CREATED DUE TO CAPITATION PROCESSING.
8451 I	DUE TO AN ADJUSTMENT SUBMITTED BY PROVIDER FOR A CLAIM TOO OLD TO PROCESS, AN ACCOUNT RECEIVABLE HAS BEEN
ļ	ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR P
8452	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR.
8453	THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG AMOUNT. WE HAVE MADE CORRECTION AND INCREASED THIS
8454	THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG AMOUNT. WE HAVE MADE CORRECTION AND DECREASED THIS
8455	THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG PROVIDER. WE HAVE CORRECTED THE ACTION AND DECREASED
8456	CLAIM DUE TO CASH RECEIPT APPLIED TO AND DECREASED AN ACCTS RECEIVABLE.
8457	AN OVER REFUND HAS BEEN APPLIED AND DECREASED THIS ACCOUNTS RECEIVABLE
8458	A STOP PAYMENT CHECK WAS APPLIED AND DECREASED THIS ACCOUNTS RECEIVABLE.
8459	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO FINANCIAL DIVISION REVIEW.
8460	THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO FINANCIAL DIVISION REVIEW
8461	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO AUDIT DIVISION REVIEW.
8462	THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO AUDIT DIVISION REVIEW.
8463	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO SURS REVIEW.
8464	THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO SURS REVIEW.
8465	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO INTEREST BEING APPLIED.
8466	THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED BY A MISCELLANEOUS ACTION
8467	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED BY A MISCELLANEOUS ACTION.
8468	THIS ACCOUNTS RECEIVABLE HAS BEEN WRITTEN OFF.
8469	THIS ACCOUNTS RECEIVABLE WAS DECREASED BY A CLAIM OFFSET
8470	CLAIM DUE TO ACCOUNT RECEIVABLE AND INCREASED DUE TO PRV UNDERPAYMENT.
	PAYMENT WITHHELD DUE TO A LIEN THAT WAS ESTABLISHED FROM A COURT ORDER.
8501 I	PAYMENT WITHHELD DUE TO AN IRS LEVY ESTABLISHED.
	PAYMENT WITHHELD DUE TO A LIEN THAT WAS ESTABLISHED FROM OTHER LEGAL ENTITY.
-	CYCLE ACTIVITY
-	DECREASE TO ORIGINAL LIEN AMOUNT RECEIVED BY LIEN HOLDER.
-	DECREASE TO ORIGINAL LIEN AMOUNT DUE TO PAYMENT RECEIVED.
-	INCREASE TO ORIGINAL LIEN AMOUNT RECEIVED BY LIEN HOLDER.
-	RELEASE OF LIEN RECEIVED BY LIEN HOLDER.
8515	VOLID VOLD TRANSACTION LIAC DEEN DROCECCED
	YOUR VOID TRANSACTION HAS BEEN PROCESSED.
	ZERO CREDIT BALANCE PROV REFUND-HEALTH INSUR PAID

EOR Code	Description
	PROV REFUND-RECIPIENT/REL PAID
	PROV REFUND-RECIPIENT/REL FAID PROV REFUND-CASUALTY INSU PAID
	PROV REFUND-PAID WRONG VENDER
8605	PROV REFUND-APPLY TO ACCT RECV
	PROV REFUND-PROCESSING ERROR
	PROV REFUND-BILLING ERROR
	PROV REFUND-FRAUD
	PROV REFUND-ABUSE
	PROV REFUND-DUPLICATE PAYMENT
	PROV REFUND-COST SETTLEMENT
	PROV REFUND-OTHER/UNKNOWN
8613	ACCT RECEIVABLE - FRAUD
8614	ACCT RECEIVABLE - ABUSE
	ACCT RECEIVABLE - TPL
8616	ACCT RECV - COST SETTLEMENT
8617	ACCT RECEIVABLE-KYMMIS REQUEST
8618	RECOUPMENT - WARRANT REFUND
	ACT RECEIVABLE-SURS OTHER
8620	ACCT RECEIVABLE - DUP PAYT
8621	RECOUPMENT - FRAUD
8622	CIVIL MONEY PENALTY
8623	RECOUPMENT-HEALTH INSUR TPL
8624	RECOUPMENT-CASUALTY INSUR TPL
8625	RECOUPMENT-RECIPIENT PAID TPL
8626	RECOUPMENT - PROCESSING ERROR
8627	RECOUPMENT - BILLING ERROR
8628	RECOUPMENT - COST SETTLEMENT
8629	RECOUPMENT - DUPLICATE PAYMENT
8630	RECOUPMENT - PAID WRONG VENDOR
8631	RECOUPMENT - SURS
8632	PAYOUT-ADVANCE TO BE RECOUPED
8633	PAYOUT - ERROR ON REFUND
8634	PAYOUT - RTP
8635	PAYOUT - COST SETTLEMENT
8636	PAYOUT - OTHER
8637	PAYOUT - MEDICARE PAID TPL
8638	RECOUPMENT - MEDICARE PAID TPL
	RECOUPMENT - DEDCO
8640	PROVIDER REFUND-OTHER TPL RSN
8641	ACCT RECV - PATIENT ASSESSMENT
8642	ACCT RECV - ORTHODONTIC FEE
8643	ACCT RECEIVABLE - KENPAC
	PARTICIP REQUIREMENTS FAILURE
8645	ACCT RECEIVABLE - OTHER
8646	AR CDR HOSP AUDIT
	ACT REC-DEMAND PAYMT UPDT 1099
8648	ACT REC-DEMAND PAYMT NO 1099
-	PCG - PART A RECOVERIES
	RECOUPMENT - COLD CHECK
	PROG INTRE POST PAY REV CONT A
	PROG INTRE POST PAY REV CONT A PROG INTRE POST PAY REV CONT B
8653	CLAIM CREDIT BALANCE
	RECOUPMENT-OTHER ST BRANCH
	RECOUPMENT - OTHER PECOLIDMENT TRI CONTRACTOR
8656	RECOUPMENT - TPL CONTRACTOR

FOR Code	Description
8657	ACCT RECV - ADVANCE PAYMENT
8658	RECOUPMENT - ADVANCE PAYMENT
8659	NON CLAIM RELATED OVERAGE
8660	PROVIDER INITIATED ADJUSTMENT
8661	PROVIDER INITIATED CLM CREDIT
8662	CLM CR-PAID MEDICAID VS XOVER
8663	CLM CR-PAID XOVER VS MEDICAID
8664	CLM CR-PAID INPATIENT VS OUTP
8665	CLM CR-PAID OUTPATIENT VS INP
8666	CLM CREDIT-PROV NUMBER CHANGED
8667	TPL CLM NOT FOUND ON HISTORY
8668	FIN CLM NOT FOUND ON HISTORY
8669	FINANCIAL WITHHOLD PAYMENT
8670	KENPAC INCENTIVE PAYMENT
8671	ENC DATA UNACCEPTABLE
8672	AR OVERAGE LT 99
8673	NO MEDICAID/PARTNERSHIP ENROLL
8674	PROV DATA UNACCEPTABLE
8675	PCP DATA UNACCEPTABLE
8676	WITHOLD OTHER
8677	RECIP INTENTIONAL PGM VIOLATE
8678	CAP ADJUSTMENT OTHER
8679	RECIPIENT NOT ELIGIBLE FOR DOS
8680	ADHOC ADJUSTMENT REQUEST
8681	ADJ DUE TO SYSTEM CORRECTIONS
8682	CONVERTED ADJUSTMENT
8683	MASS ADJ WARR REFUND
8684	DMS MASS ADJ REQUEST
8685	MASS ADJ SURS REQUEST
8686	THIRD PARTY PAID - TPL
8687	CLAIM ADJUSTMENT - TPL
8688	BEGINNING DUMMY RECOUPMENT BAL
8689	ENDING DUMMY RECOUPMENT BAL
8690	RETRO RATE MASS ADJ
8691	BEGINNING CREDIT BALANCE
8692	ENDING CREDIT BALANCE
8693	BEGINNING DUMMY CREDIT BALANCE
8694	ENDING DUMMY CREDIT BALANCE
8695	BEGINNING RECOUPMENT BALANCE
8696	ENDING RECOUPMENT BALANCE
8697	BEGIN DUMMY REC BAL
8698	END DUMMY RECOUP BALANCE
8699	UNIT DOSE RETURN DRUG ADJ
8700	PCG 2 PART A RECOVERIES
8701	PCG 2 PART B RECOVERIES
8702	PCG 2 AR CDR HOSP
8703	CONVERTED CLAIM CREDIT BALANCE
8704	DRG RETRO REVIEW
8705	DECEASED RECIPIENT RECOUPMENTS
8706	IMPACT PLUS
8707	INTEREST RECEIVED
8708	PROG INTRE POST PAY REV CONT C
8709	ON DEMAND RECOUPMENT REFUND
8710	RECOUP PAYOUT
8711	RECOUPMENT REFUND

FOR Code	Description
8712	STATE SHARE
8713	KYMMIS MEDICARE PART A RECOUP
8714	REG. PSYCH. CROSSOVER REFUND
8998	CLAIM BEING REVIEWED
8999	ADJUSTMENT TO CROSSOVER PAID PRIOR TO 1/1/95. THIS CLAIM HAS BEEN MANUALLY PRICED USING THE MEDICARE
9000	THE SUBMITTED CHARGE EXCEEDS THE ALLOWED CHARGE. CLAIM PAID AT THE KY MEDICAIDALLOWED AMOUNT.
9001	REIMBURSEMENT REDUCED BY THE MEMBER'S CO-PAYMENT AMOUNT.
9002	ACTUAL ITEMIZED COST INVOICE MUST BE SUBMITTED WHEN BILLING THIS PROCEDURE CODE. PLEASE RESUBMIT WITH AN INVOICE.
9003	NO PAYMENT MADE-TPL/SPENDDOWN IS MORE THAN THE ALLOWED AMOUNT.
9004	PERSONAL RESOURCE AMOUNT DEDUCTED FROM THE ALLOWED AMOUNT.
9005	COMPLETE PROCEDURE NOT PAYABLE WHEN THE TECHNICAL AND PROFESSIONAL COMPONENTS HAVE BEEN PAID FOR THE SAME
9006	THIS ITEM SHOULD NOT BE BILLED WITH THIS PROCEDURE CODE.
9007	A PROCEDURE CODE IS REQUIRED WHEN BILLING THIS REVENUE CODE. PLEASE RESUBMIT WITH A PROCEDURE CODE.
9008	LINE ITEM SUBMITTED WITH UNCLEAR ITEMIZATION. PLEASE RESUBMIT WITH APPROPRIATEAND/OR ADDITIONAL INFORMATION.
9009	SERVICE DENIED. REIMBURSEMENT FOR INPATIENT HOSPITAL CARE LIMITED TO ONCE PER DAY.
9010	SERVICE IS NON-COVERED UNDER THE OKLAHOMA HEALTH COVERAGE PROGRAM
9011	SUPPORTING DOCUMENTATION IS NEEDED FOR THE MODIFIER(S) SUBMITTED ON THIS CLAIM.
9012	WRONG CLAIM FORM SUBMITTED. PLEASE RESUBMIT ON A UB92 CLAIM FORM.
9013	CLAIM UNDER REVIEW - FOR INTERNAL USE ONLY
9015	MCO CANNOT ADJUST OR VOID A FEE-FOR-SERVICE CLAIMS AND VICE VERSA.
9016	THE OVERHEAD OCCURRENCE DATES BILLED ON THE CLAIM DO NOT AGREE WITH THE DATES OF SERVICE BILLED ON THE CLAIM
9017	SEPARATE REIMBURSEMENT IS NOT AVAILABLE FOR COMPONENT PROCEDURES WHEN GLOBAL PROCEDURE HAS BEEN PAID.
9018	837 ADJUSTMENT ERROR MEMBER MEDICAID ID NOT PRESENT
9019	837 ADJUSTMENT ERROR CROSSOVER PROVIDER ID NOT PRESENT
9020	837 ADJUSTMENT ERROR PROVIDER ID NOT PRESENT
9021	837 ADJUSTMENT ERROR UNABLE TO FIND ORIGINAL ICN
9022	YOU CANNOT ADJUST OR VOID A THRESHOLDED ENCOUNTER.
9023	837 ADJUSTMENT ERROR RECIPIENT NOT FOUND
9024	837 ADJUSTMENT ERROR PROVIDER NOT FOUND
9025	837 ADJUSTMENT ERROR MATCHING CLAIM NOT FOUND
9026	837 ADJUSTMENT ERROR CLAIM HAS ALREADY BEEN ADJUSTED
9027	837 ADJUSTMENT ERROR CLAIM IS SCHEDULED TO BE ADJUSTED BY ANOTHER PROCESS
9028	837 ADJ ERROR- PROV/TAXNMY/ZIP NOT MATCHING ORGIN
9029	837 ADJ-CURRENT CLAIM TYPE NOT MATCHING ORIGN
9030	CRITICAL CARE/NEONATAL INTENSIVE CARE VISIT CODES NOT PAYABLE WHEN THE AMOUNT PREVIOUSLY PAID FOR PROCEDURES
9031	GLOBAL IMMUNIZATION PROCEDURE CODES NOT PAYABLE WHEN THE AMOUNT PREVIOUSLY REIMBURSED FOR THE RELATED
	COMPONENT IMMUNIZATION PROCEDURE(S) EQUALS THE REIMBURSE
9032	CLAIM DENIED. EDI ADJUSTMENT NOT ALLOWED FOR ELECTRONIC CLAIM WITH ATTACHMENTS.
9036	ORAL SURGERY NOT PAYABLE WHEN AMOUNT PAID FOR APICOECTOMY ON SAME DATE OF SERVICE EXCEEDS OKLAHOMA HEALTH
	COVERAGE PROGRAM ALLOWABLE FOR THE PROCEDURE BILLED.
9040	REIMBURSEMENT IS FOR THE VFC (VACCINE FOR CHILDRENS PROGRAM) VACCINE ADMINISTR ATION FEE ONLY
9075	CLAIM DENIED. STERILIZATION CONSENT FORM INCOMPLETE OR IMPROPERLY COMPLETED.A STERILIZATION CHECKLIST AND YOUR
9080	NON COVERED CHARGES
9090	XOVER W/O MEDICARE SEGMENT FOR REVIEW
9091	NO MEDICARE CROSSOVER COPAY DUE
9107	FULL SERIES SPINAL X-RAY NOT PAYABLE WHEN THE AMOUNT PAID FOR COMPONENTS OF THESPINAL SERIES X-RAYS WITHIN THE
9111	INTERNAL PROCESSING ERROR - CONTACT SE MANAGER
9122	NO PRICING METHOD ASSIGNED OR UNKNOWN
9175	CLAIM DENIED. MEMBER'S SIGNATURE AND DATE OF SIGNATURE IN THE MEMBER'S SECTIONOF THE CONSENT FORM ARE IN ERROR
9256	TREND EVENT MONITOR IS REIMBURSABLE TO A MAXIMUM OF \$850.00 PER MONTH, BUT IS NOT PAYABLE WHEN RELATED
	COMPONENTS HAVE BEEN REIMBURSED FOR THE MAXIMUM AMOUNT.
9257	MAXIMUM REIMBURSEMENT FOR OXIMETRY IS \$280.00 PER 30 DAYS. MAXIMUM REIMBURSEMENT HAS BEEN PAID.
9260	PARENTERAL/ENTERAL FEEDING KIT PAYABLE AT A REDUCED AMOUNT WHEN RELATED SUPPLIES HAVE BEEN PAID WITHIN THE SAME
9300	MASS ADJUSTMENT SUSPENDED FOR REVIEW
9302	INVALID BENEFIT PLAN ON CLAIM

EOB Code	Description
9303	UNABLE TO ASSIGN PROVIDER CONTRACT
9304	DUE TO CONDITIONS NOT PRESENT ON ADMISSION, SOME DIAGNOSIS CODES WERE NOT CONSIDERED IN THE DRG ASSIGNMENT
9400	THE NUMBER OF SERVICES EXCEED MEDICAL POLICY GUIDELINES. PRIOR AUTHORIZATION REQUIRED FOR ADDITIONAL SERVICES.
9500	SUPPLEMENTAL CLAIM CREATED DUE TO MCO ENCOUNTER RECEIVED.
9501	SUPPLEMENTAL CLAIM CREATED DUE TO MCO ENCOUNTER RECEIVED. NO SUPPLEMENTAL PAYMENT DUE.
9502	PAID AMOUNT OF A FEE-FOR-SERVICE MY REWARDS CLAIM HAS BEEN DEDUCTED FROM YOUR SUPPLEMENTAL CLAIM PAYMENT.
9600	REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF LENSES PER YEAR FOR MEMBERS 18 YEARS OF AGE AND UNDER.
9601	REIMBURSEMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF FRAMES PER YEAR FOR MEMBERS 18 YEARS OF AGE AND UNDER.
	PROVIDERS MUST SUBMIT XP-MODIFIER WHEN MEMBERS
9603	THE DATE OF SERVICE ON THIS CLAIM MATCHES THE MEMBER'S SPENDOWN MET DATE FORTHE MONTH. AN 8A FORM IS REQUIRED.
9604	REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF LENSES EVERY (2) TWO YEARS FOR MEMBERS 19 YEARS OF AGE OR
9605	HOSPITAL LEAVE DAYS ARE LIMITED TO 15 PER HOSPITALIZATION. THE PATIENT SHOULD BE DISCHARGED AND READMITTED
9634	COMPLETE PROCEDURE NOT PAYABLE WHEN THE TECHNICAL AND PROFESSIONAL COMPONENTS HAVE BEEN PAID FOR THE SAME
9651	SURGERIES ON THE SAME DATE OF SERVICE, IN THE EXCESS OF TWO, ARE PAID AT 25 PERCENT OF THE OKLAHOMA HEALTH
9660	THIS SERVICE IS NOT PAYABLE, MEMBER IS QMB ALSO AND SPENDDOWN HAS NOT BEEN MET FOR THE MONTH. ONLY
	REIMBURSEMENT FOR COINSURANCE AND DEDUCTIBLE ON CLAIMS CRO
9661	POS REVERSAL PROCESSING DEFERRED DURING FINANCIAL CYCLE
9662	CLAIM DENIED. ATTACHMENT NOT RECEIVED.
9663	ATTACHMENT BEING SENT BY PROVIDER FOR AN ELECTRONIC CLAIM.
9664	THE NUMBER OF QUADRANTS BILLED ON THE CLAIM IS NOT EQUAL TO THE NUMBER OF UNITS BILLED.
9665	TOOTH NUMBERS CANNOT BE BILLED WITH A PROCEDURE THAT REQUIRES QUADRANTS.
9666	THE ATTACHMENT TYPE IS NOT VALID.
9700	THE DISPENSING FEE HAS BEEN REDUCED TO THE ALLOWABLE
9701	THE QUANTITY DISPENSED HAS BEEN REDUCED TO THE ALLOWABLE QUANTITY
9702	DOLLARS ADJUSTED TO PARAMETER LIMIT
9703	QTY ADJUSTED TO PARAMETER LIMIT
9704	COVERED DAYS REDUCED TO ALLOWABLE
9705	VISITS REDUCED TO AUTHORIZED
9706	PA CHARGE REDUCED TO AUTHORIZED
9707	PA UNITS REDUCED TO AUTHORIZED
9708	THER DAYS REDUCED TO AUTHORIZED
9709	MAX 14 CONSECUTIVE THER DAYS ALLOWED
9710	HOSP LEAVE DAYS REDUCED TO AUTHORIZED
9800	CUTBACK DUE TO HMO PAYMENT
9878	THE SUM OF THE OTHER PAYER DETAIL PAID AMOUNT PLUS THE OTHER PAYER CLAIM DETAILADJUSTMENT AMOUNTS MUST EQUAL
9900	REIMBURSEMENT LIMITED TO ONE SET OF LENSES PER YEAR FOR MEMBERS 18 YEARS OF AGE AND YOUNGER UNLESS REPAIRS OR
	REPLACEMENTS ARE DUE TO EXTENUATING CIRCUMSTANCE
9901	REIMBURSEMENT LIMITED TO ONE SET OF FRAMES PER YEAR FOR MEMBERS 18 YEARS OF AGE AND YOUNGER UNLESS REPAIRS OR
	REPLACEMENT IS DUE TO EXTENUATING CIRCUMSTANCES
9902	PROCEDURE CODE GROUP NOT FOUND
9903	REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF FRAMES EVERY (2) YEARS FOR MEMBERS 19 YEARS OF AGE OR
9904	SERVICE DENIED. REIMBURSEMENT LIMITED TO ONE SET OF LENSES EVERY TWO YEARS FORMEMBERS 19 YEARS OR OLDER UNLESS
9905	SERVICE DENIED-MEDICAL NECESSITY DOCUMENTATION MUST BE PROVIDED WITH CLAIM STATING REASON FOR MEDICAL
9906	PRICING ADJUSTMENT - MEDICARE PART B PRICING APPLIED
9907	TPL AMOUNT APPLIED
9908	PRICING ADJUSTMENT - PHARMACY PRICING APPLIED
9909	PRICING ADJUSTMENT - 50% OF AMOUNT BILLED APPLIED
9910	PHARMACY DISPENSING FEE APPLIED
9911	PRICING ADJUSTMENT - LONG TERM CARE PRICING APPLIED
9912	PRICING ADJUSTMENT - AMBULATORY SURGERY PRICING APPLIED
9913	PRICING ADJUSTMENT - OUTPATIENT EPOGEN PRICING APPLIED
9914	PRICING ADJUSTMENT - REVENUE CODE RATE PRICING APPLIED
9915	PRICING ADJUSTMENT - MEDICARE PART A PRICING APPLIED
9916	
3310	PRICING ADJUSTMENT - UCC RATE PRICING APPLIED

FOR Code	Description
9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
9919	PRICING ADJUSTMENT - MAX FEE FRICING APPLIED PRICING ADJUSTMENT - PROVIDER LOC PRICING APPLIED
9920	PRICING ADJUSTMENT - PROVIDER LOC PRICING APPLIED PRICING ADJUSTMENT - RBRVS PRICING APPLIED
9921	PRICING ADJUSTMENT - RERVS PRICING APPLIED PRICING ADJUSTMENT - PA PRICING APPLIED
9921	
	SPENDDOWN DEDUCTIBLE/PATIENT LIABILITY APPLIED
9923	SPENDDOWN PATIENT LIABILITY APPLIED
9924	CLAIM HAS FICA AMOUNT
9925	CLAIM HAS RECOUPMENT AMOUNT
9926	CLAIM HAS CUTBACK AMOUNT
9927	SYSTEM FUND CODE REASSIGNMENT
9928	PRICING ADJUSTMENT - COVID VACCINATION ADMINISTRATION OR CHW PRICING APPLIED.
9930	REVENUE CODE ZERO PAID WHEN BILLED WITH THIS PROCEDURE CODE.
9931	PRICING ADJUSTMENT - 100% MEDICARE COINS. & DEDUCT APPLIED
9932	PRICING ADJUSTMENT - DRG PRICING APPLIED
9933	PRICING ADJUSTMENT - APC PRICING APPLIED
9935	PRICING ADJUSTMENT - MAX FLAT FEE PRICING APPLIED
9936	PRICING ADJUSTMENT - MAX FLAT FEE 2 PRICING APPLIED
9937	PRICING ADJUSTMENT - UCC FLAT FEE PRICING APPLIED
9938	PRICING ADJUSTMENT - UCC FLAT FEE 2 PRICING APPLIED
9939	PRICING ADJUSTMENT - SCHOOL BASED GROUP PRICING APPLIED
9940	PRICING ADJUSTMENT - PROVIDER PERCENT BILLED APPLIED
9941	PRICING ADJUSTMENT - LESSER PA/MAX FEE PRICING APPLIED
9942	PRICING ADJUSTMENT- MEMBER COUNTY PRICING APPLIED.
9943	PRICING ADJUSTMENT-HOSPICE CROSSWALK PRICING APPLIED.
9944	PRICING ADJUSTMENT - LESSER PA/MAX FEE PRICING APPLIED
9945	PRICING ADJUSTMENT - PROVIDER UNIT RATE PRICING APPLIED
9946	PRICING ADJUSTMENT- PROVIDER SPECIFIC PER DIEM RATES APPLIED
9947	PRICING ADJUSTMENT - BUNDLED RATE PRICING APPLIED
9948	OUTPATIENT ASC PRICING APPLIED
9949	INPATIENT AUTOMATED TRANSPLANT PRICING APPLIED
9950	PRICING ADJUSTMENT- PPDADD PRICING APPLIED
9951	PRICING ADJUSTMENT- PROVIDER MAX PER DIEM PRICING APPLIED
9952	PRICING ADJUSTMENT- REVENUE PCT PRICING APPLIED
9953	PRICING ADJUSTMENT- ZERO PAID PRICING APPLIED
9954	KY DEFAULT PERCENTAGE PRICING APPLIED
9955	PRICING ADJUSTMENT - LESSER ANESTHESIA PRICING APPLIED
9956	PRICING ADJUSTMENT - NDC PRICING APPLIED
9957	PRICING ADJUSTMENT - REVENUE FEE PERCENTAGE PRICING APPLIED.
9958	PRICING ADJUSTMENT - PROVIDER PERCENTAGE OF PER DIEM PRICING APPLIED.
9965	TOOTH NUMBERS CANNOT BE BILLED WITH A PROCEDURE THAT REQUIRES A QUADRANT.
9970	PRICING ADJUSTMENT - LT1918 PRICING APPLIED
9971	PRICING ADJUSTMENT - LTCPTA PRICING APPLIED
9972	PRICING ADJUSTMENT - LTNQMB PRICING APPLIED
9973	PRICING ADJUSTMENT - LTPD18 PRICING APPLIED
9975	PRICING ADJUSTMENT - LTCDME PRICING APPLIED
9977	CLAIM DENIED. THE SUM OF ALL LINE LEVEL PAYMENT AMOUNTS LESS ANY CLAIM LEVEL ADJUSTMENT AMOUNTS DOES NOT
9980	PROVIDER TYPE SPECIALTY GROUP NOT FOUND
9981	DIAGNOSIS CODE GROUP NOT FOUND
9981	ICD PROCEDURE CODE GROUP NOT FOUND
9983	MODIFIER CODE GROUP NOT FOUND
-	
9985	NDC DRUG TYPE GROUP NOT FOUND
9986	REVENUE CODE GROUP NOT FOUND
9987	DRG CODE GROUP NOT FOUND
9988	TYPE OF BILL GROUP NOT FOUND
9990	BENEFIT PLAN TYPE GROUP NOT FOUND

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