EOB Code	Description
1	PLEASE VERIFY THE DATES OF SERVICE. HEADER FROM DATE OF SERVICE IS MISSING OR INVALID.
2	THE ADMITTING DATE OF SERVICE IS MISSING/INVALID OR LATER THAN THE FROM DATE OF SERVICE.
3	PLEASE VERIFY THE DATES OF SERVICE. THE TO DATE OF SERVICE IS INVALID, MISSING, FUTURE DATE OR LESS THAN THE FROM DATE OF SERVICE.
4	MEDICARE PAID DATE IS MISSING OR INVALID.
5	EACH PROVIDER IS LIMITED TO BILLING ONLY 1 OF THE FOLLOWING PROCEDURES(HOSP ADM,ER VIS,CONSULT,OV)/MEMBER/SAME DOS. YOU HAVE ALREADY RECEIVED PAYMENT FOR 1OF
6	THE DISCHARGE DATE IS MISSING OR INVALID.
7	TOTAL DAYS DO NOT EQUAL THE DIFFERENCE BETWEEN FROM AND TO DATES.
8	CLAIM DENIED REQUEST FOR PAYMENT WAS REC'D BEYOND MEDICAID FILING LMT CLAIMS MUST BE FILED WITHIN 1 YR OF THE DOS OR WITHIN 6 MONTHS OF MEDICARE PD DATE WHICH
9	CLAIM DENIED. RESEARCH DATA UNAVAILABLE TO PROCESS CLAIM PLEASE RESUBMIT CLAIMWITH ITEMIZED BILL. SUMMARY STATEMENT FOR ENTIRE ADMISSION.
10	CLAIM DENIED. PLEASE RESUBMIT CLAIM WITH ANESTHESIA REPORT.
11	NUMBER OF UNITS BILLED IS NOT EQUAL TO DATE SPAN
12	ONLY ONE UNIT IS PAYABLE PER DATE OF SERVICE FOR THIS SERVICE. UNITS OF SERVICE CHANGED TO ONE.
13	DISCHARGE DATE IS PRIOR TO THROUGH DATE OF SERVICE.
14	CODE INDICATING SUPERVISING PROFESSIONAL IS MISSING/INVALID.
15	CLAIM/DETAIL DETAIL DENIED. PROCEDURE IS LIMITED TO THE FOLLOWING CONDITIONS - CONGENITAL, HEREDITARY OR DRUG INDUCED
16	CLAIM/DETAIL DENIED. PROCEDURE IS LIMITED TO TRAUMA RELATED INJURIES.
17	LONG TERM CARE DAYS BILLED IS GREATER THAN THE NUMBER OF DAYS IN BILLING MONTH.
18	CLAIM DENIED. ACCOMMODATION/ANCILLARY CODE MISSING OR INVALID.
19	CLAIM/DETAIL DENIED. PROCEDURE/NDC MISSING/INVALID.
20	MEDICARE DOCUMENTATION NOT ATTACHED.
21	CLAIM DENIED. PHYSICIAN ON REPORT AND PHYSICIAN BILLING DO NOT MATCH.
22	COVERED DAYS ARE NOT EQUAL TO ACCOMMODATION UNITS.
23	CLAIM DENIED. NO PHYSICIAN PATIENT CONTACT.
24	THE DETAIL BILLED AMOUNT IS MISSING OR INVALID.
25	CLAIM SUBMITTED FOR INFORMATIONAL PURPOSE ONLY. NO PAYMENT IS TO BE MADE.
26	CLAIM DENIED. LONG TERM CARE SUPPLEMENTAL BILLING MUST BE SUBMITTED AS AN ADJUSTMENT.
27	CLAIM DENIED. RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM.
28	CLAIM/DETAIL DENIED. DATA ILLEGIBLE. PLEASE RESUBMIT.
29	CLAIM REQUIRES DOCUMENTATION. PLEASE RESUBMIT ON PAPER. DEPENDENT ON SPECIFICPROCEDURE CODE AND CRITERIA SET FOR REVIEW.
30	CLAIM/DETAIL DENIED. DETAIL NUMBER OF SERVICES MISSING.
31	CLAIM DENIED. LEVEL OF CARE MISSING. PLEASE CORRECT AND RESUBMIT.
32	CLAIM DENIED. UNIT OF MEASURE INVALID. DOES NOT MATCH NDC UNIT OF MEASURE.
33	NUMBER OF UNITS BILLED LESS THAN 30 FOR INSULIN SYRINGES
34	DENIED BY MEDICARE.
35	DETAIL DENIED. THIS SERVICE NOT PAYABLE ON THIS DATE OF SERVICE
36	CLAIM DENIED. ONLY 1 DATE OF SERVICE ALLOWED PER CLAIM FORM.
37	MODEL WAIVER 1 MEMBER LIMITED TO 24 HOURS OF NURSING SERVICES PER DATE OF SERVICE.
38	CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR PLACE OF SERVICE.
39	THIS PROCEDURE CODE IS LIMITED TO TWO UNITS OF SERVICE PER DATE OF SERVICE.
40	CLAIM/DETAIL DENIED. TYPE OF BILL INVALID OR MISSING.
41	DRUG MANAGEMENT AND MEDICAL PSYCHOTHERAPY NOT ALLOWED FOR SAME DATE OF SERVICE, PROVIDER, MEMBER.
42	CLAIM DENIED. COINSURANCE AND/OR DEDUCTIBLE GREATER ON CLAIM THAN EOMB.
43	CLAIM DENIED. VOUCHER NUMBER MISSING OR INVALID.
44	CLAIM DETAIL DENIED. REVENUE CODE MISSING OR INVALID.
45	TYPE OF BILL INVALID FOR PROVIDER TYPE.
46	CLAIM DENIED. HCPCS CODE BILLED INVALID/OBSOLETE. RESUBMIT WITH CORRECT CODE.
47	PROFESSIONAL COMPONENT BILLED. CLAIM MANUALLY PRICED TO MAXIMUM ALLOWABLE
48	CLAIM DENIED. MEDICARE PAID PATIENT, REFER TO DMS PROVIDER SERVICES MAN UAL AND RESUBMIT.
49	CLAIM/DETAIL DENIED. MEDICARE PAID AMOUNT GREATER THAN OR EQUAL TO TOTAL BILLED AMOUNT.
50	CLAIM DENIED. PLEASE CORRECT COVERED DAYS FIELD AND RESUBMIT
51	PATIENT CONDITION/STATUS CODE MISSING, INVALID, OR INVALID FOR TYPE OF BILL.
52	ERROR ON CLAIM RELATED TO DOLLAR AMOUNTS -CLAIM IN PROCESS.
53	CLAIM/DENIED. NET BILLED NOT EQUAL TO TOTAL BILLED MINUS OTHER INSURANCE.
54	CLAIM DENIED. OTHER INSURANCE AMOUNT MUST BE MANUALLY COMPUTED FOR THIS CLAIM
55	CLAIM DENIED TOTAL DETAIL CHARGES NOT EQUAL TO TOTAL BILLED.
56	CLAIM/DETAIL DENIED. ASSISTANT SURGEON SERVICES NOT PAYABLE FOR A VAGINAL DELIVERY.
57	INVALID TYPE OF BILL FOR CORF/ORF PROVIDER SPECIALTY.
58	CLAIM/DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL.
59	CLAIM/DETAIL DENIED. NET BILLED CHARGE MISSING OR INVALID.
60	CLAIM DENIED. LOCATION CODE INVALID.
61	PAID IN FULL BY MEDICAID.
62	CLAIM DENIED. THE HOUR OF ADMISSION IS MISSING OR INVALID.
63	CLAIM DENIED. LONG TERM CARE FACILITY NUMBER MUST BE ENTERED IN FACILITY ID FIELD.
64	THE TIME OF PICK UP IS BEFORE THE TIME OF CALL IN.
65	DESTINATION CODE IS MISSING/INVALID.
66	PRO STICKER/INDICATOR MISSING OR INVALID
67	FAMILY PLANNING INDICATOR INVALID.
68	AM/PM PICK-UP INDICATOR MISSING OR INVALID.
69	TIME OF CALL IN MISSING/INVALID.
70	TIME OF PICK UP IS MISSING OR INVALID.
71	DESTINATION CODE MISSING/INVALID.
72	PICK-UP LOCATION CODE MISSING OR INVALID.
73	REFERRED TO 'OTHER' CODE INVALID.
74	ANCILLARY CHARGES NOT PAYABLE IN CONJUNCTION WITH VENTILATOR OR BRAIN INJURY PROGRAM REIMBURSEMENT.
75	CLAIM DENIED. QUANTITY DOES NOT MATCH PACKAGE SIZE OR A MULTIPLE OF THE PACKAGE SIZE.
76	OTHER MEANS OF TRANSPORTATION CODE MISSING OR INVALID.
77	CLAIM DETAIL/DENIED. TIME OF CALL-IN AM/PM INDICATOR MISSING
78	CLAIM/DETAIL DENIED. BASE RATE OR RATE PER MILE MISSING OR INVALID.
79	CLAIM/DETAIL DENIED. DETAIL TOTAL BILL NOT=(RATE PER MILE X EXTRA MILES).
80	PROVIDER TYPE INVALID FOR CATEGORY OF SERVICE.
81	CLAIM DENIED. NUMBER OF PERSONS SHARING RIDE INVALID.
82	CLAIM DENIED. TYPE OF TRIP MISSING OR INVALID.
83	CLAIM DENIED. SECONDARY SURGERY DATE MISSING/INVALID
84	CLAIM DENIED. PRIMARY SURGERY DATE MISSING/INVALID.
85	CLAIM DENIED/INVALID LINE ITEM PROVIDER LICENSE NUMBER
86	PROVIDER INELIGIBLE FOR DATE OF SERVICE. PLEASE CONTACT PROVIDER ENROLL MENT AT (877) 838-5085 OR (877) 838-5085 FOR NF OR ICF/MR.
87	CLAIM DENIED. TO DATE OF SERVICE EQUAL TO DATE OF RECEIPT.
88	CLAIM DENIED. CLAIM INVOICE DATE MISSING/INVALID.
89	DETAIL CHARGE MISSING OR INVALID.
90	CLAIM DENIED. EPSDT DISPOSITION CODE MISSING OR INVALID.
91	CLAIM DENIED. YOU MUST INDICATE IN BLOCK 15 IF THIS WAS A PARTIAL, COMPLETE, OR COMPLETION OF A PARTIAL EXAM FOR PROCESSING.
92	THIS SERVICE DENIED. PLEASE RESUBMIT CLAIM WITH COPY OF PATHOLOGY REPORT.
93	THIS SERVICE DENIED. PLEASE RESUBMIT WITH HISTORY AND PHYSICAL NOTES.
94	PHYSICIAN SIGNATURE AND DATE ON CONSENT FORM MUST BE ON OR AFTER DATE OF SERVICE

95	CONSENT FORM IS ILLEGIBLE. RESUBMIT LEGIBLE COPY WITH CLAIM
96	MEMBER'S SIGNATURE ON CONSENT FORM MUST BE ON OR BEFORE DATE OF SERVICE.
97	DATES OF SERVICE ON CLAIM AND CONSENT FORM DISAGREE.
98	MEMBER MUST BE 21 TO LEGALLY SIGN THE FEDERAL STERILIZATION CONSENT FORM.
99	PERSON OBTAINING CONSENT MUST SIGN ON OR AFTER DATE OF MEMBER SIGNATURE BUT PRIOR TO THE STERILIZATION PROCEDURE. CLAIM NOT PAYABLE BY MEDICAID.
100	DETAIL FROM DATE OF SERVICE MISSING OR INVALID.
101	DETAIL TO DATE OF SERVICE MISSING OR INVALID.
102	CLAIM DETAIL DENIED. LATE BILLING DATE OF SERVICE PAST ONE YEAR FILING LIMIT. VERIFIES THAT EACH DETAIL OF A CLAIM IS RECEIVED WITHIN 1 YEAR FROM THE DATE OF
103	MISSING OR ALTERED MEMBER SIGNATURE OR DATE ON CONSENT FORM IS NOT ACCEPTABLE.CLAIM NOT PAYABLE BY MEDICAID.
105	CLAIM DENIED. CLAIM SUBMITTED FOR HEARING AID AND HEARING AID PARTS SHALL REFLECT THE ACTUAL LABORATORY COST OF THE MATERIALS. INVOICE AND CLAIM MUST MATCH.
106	INCLUDED IN FLAT FEE FOR MAJOR PROCEDURES.
107	INCLUDED IN REIMBURSEMENT FOR OFFICE VISIT
108	CONSENT FORM IS INCOMPLETE
109	INCORRECT STERLIZATION CONSENT FORM USED.
110	CLAIM SUSPENDED FOR REVIEW.
111	ADJUSTMENT REQUEST IN PROCESS
112	CLAIM DENIED. DOCUMENTATION ATTACHED WAS INSUFFICIENT TO WAIVE ONE YEAR FILINGLIMITATION. PLEASE CALL PROVIDER SERVICES FOR ASSISTANCE.
113	CLAIM DENIED. REQUIRED DOCUMENTATION MISSING/INCOMPLETE.
114	REQUIRED CONSENT FORM DOCUMENTATION WAS NOT COMPLETED PRIOR TO STERILIZATION PROCEDURE. CLAIM NOT PAYABLE BY MEDICAID.
115	PAYMENT APPLIED TO RECEIVABLE.
116	DOCUMENTATION OF MEDICAL NECESSITY REQUIRED. CONSULT YOUR PROVIDER MANUAL.
117	CLAIM DENIED. THIS TYPE OF BILL NOT VALID FOR DRG-RELATED CLAIM.
118	OUR RECORDS INDICATE PAID IN FULL BY MEDICARE.
119	NOT COVERED UNDER THE PROGRAM EXCEPT UNDER EPSDT.
120	LAB PROCESSING CHARGE INCLUDED IN FLAT FEE.
121	THIS SERVICE IS NOT PAYABLE FOR A QMB-ONLY MEMBER
122	THIS SERVICE WAS NOT APPROVED BY MEDICARE. PLEASE RESUBMIT THIS SERVICE TO MEDICAID WITH A COPY OF THE MEDICARE EOMB.
123	CLAIM DENIED. THIS CLAIM MAY NOT SPAN THE MEMBER'S 1ST BIRTHDAY. PLEASE REFER TO THE BILLING INSTRUCTIONS IN YOUR PROVIDER MANUAL.
124	CLAIM DENIED. MENTAL HOSPITAL SERVICES ARE NOT PAYABLE FOR MEMBERS AGE 22 THROUGH 64.
125	THE TOOTH NUMBER IS MISSING OR INVALID.
126	PROCEDURE CODE(S) IS INVALID FOR OTHER THAN ANTERIOR TOOTH NUMBERS.
127	CLAIM/DETAIL DENIED. TOOTH SURFACE IS INVALID.
128	THE TOOTH NUMBER IS MISSING OR INVALID.
129	KYCONV-DESCRIPTION NOT FOUND
130	CLAIM/DETAIL DENIED. THE DAILY LIMITATION FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED.
131	CLAIM/DETAIL DENIED. CERTAIN TITLE V PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 12 HOURS PER DAY.
132	SERVICE NOT AUTHORIZED.
133	THIS PROCEDURE REQUIRES PRIOR AUTHORIZATION (PA). CURRENTLY, EDITING
134	MAP-34 FORM INCOMPLETE.
135	CLAIM/DETAIL DENIED. FULL MOUTH DEBRIDEMENT IS ONLY PAYABLE FOR
136	PLEASE INDICATE THE CORRECT PLACE OF SERVICE CODE.
137	CLAIM DENIED. SERVICES MUST BE BILLED IN CONJUNCTION WITH APPROPRIATE ROOM CHARGES.
138	CLAIM DENIED. LOCK-IN MEMBER.
139	CLAIM/DETAIL DENIED. ASSESSMENTS ARE LIMITED TO 20 UNITS PER CALENDAR YEAR, PER MEMBER.
140	CLAIM PENDING REVIEW. MEMBER IS A POTENTIAL LOCK-IN MEMBER.
141	PROCEDURE CODE MODIFIER MISSING/INVALID.
142	CLAIM DENIED. PREGNACY INDICATOR INVALID FOR MEMBERENT AGE OR SEX.
143	CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR PROVIDER TYPE.
144	SHOULD BE BILLED BY PROVIDER OF SERVICE.
145	THIS PROCEDURE IS NOT CERTIFIED FOR THIS LABORATORY.
146	THIS PROCEDURE IS NOT COVERED FOR THIS PROVIDER TYPE.
147	PROCEDURE CODE IS NOT ALLOWED WITH PROVIDER TYPE MODIFIER.
148	THIS PROCEDURE IS NOT APPROPRIATE FOR THIS PLACE OF SERVICE.
149	THIS PROCEDURE/NDC IS NOT APPROPRIATE FOR THE MEMBER'S AGE.
150	THIS PROCEDURE IS INVALID FOR THE MEMBER'S SEX.
151	CLAIM DENIED. PROCEDURE NDC CODE INVALID FOR DATES OF SERVICE
152	PROCEDURE/NDC/REVENUE CODE MISSING OR NOT COVERED BY KENTUCKY MEDICAID.
153	PROCEDURE CODE INVALID FOR DIAGNOSIS CODE
154	PROCEDURE CODE INVALID FOR PROVIDER TYPE MODIFIER.
155	PLEASE RESUBMIT WITH APPROPRIATE GROUP PROVIDER NUMBER IN CLINIC FIELD AND/OR INDIVIDUAL PROVIDER NUMBER IN BILLING FIELD.
156	THE INTERIM RATE FOR THIS PROCEDURE HAS NOT BEEN ESTABLISHED FOR THIS PROVIDER.
157	PROCEDURE CODE INVALID FOR PROVIDER SPECIALTY.
158	CLAIM DENIED DUE TO INJURY DIAGNOSIS.
159	MORE THAN ONE VISIT PER DETAIL DATE OF SERVICE NOT ALLOWED. EACH VISIT MUST BE BILLED AS SEPARATE LINE ITEMS.
160	PROCEDURE INVALID FOR TOOTH NUMBER INDICATED.
161	CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR DATE OF SERVICE.
162	CLAIM DENIED. ANTINEOPLASTIC DRUGS AND CHEMOTHERAPY ADMIN ARE PAYABLE ONLY IF THE DIAGNOSIS IS MALIGNANCY.
163	CLAIM DETAIL DENIED. EMPLOYEE ID/PERSONAL IDENTIFIER MISSING OR INVALID.
164	PRIMARY SURGICAL PROCEDURE CODE MISSING OR NOT ON FILE.
165	SECONDARY SURGICAL PROCEDURE CODE MISSING OR NOT ON FILE.
166	CLAIM/DETAIL DENIED. PRIMARY SURGICAL PROCEDURE CODE INVALID FOR MEMBER'S AGE.
167	SECONDARY SURGICAL PROCDURE CODE INVALID FOR MEMBERS AGE.
168	PRIMARY SURGICAL PROCEDURE CODE INVALID FOR MEMBERS SEX.
169	SECONDARY SURGICAL PROCEDURE CODE INVALID FOR MEMBERS SEX
170	PRIMARY SURGICAL PROCEDURE CODE INVALID FOR DATE OF SERVICE.
171	SECONDARY SURGICAL PROCEDURE CODE INVALID FOR DATE OF SERVICE.
172	SURGICAL PROCEDURE CODE INVALID FOR DIAGNOSIS CODE
173	SECONDARY SURGICAL PROCEDURE CODE INVALID FOR DIAGNOSIS CODE
174	PROVIDER ON REVIEW FOR PRIMARY SURGICAL PROCEDURE
175	PROVIDER ON REVIEW FOR SECONDARY SURGICAL PROCEDURE
176	SURGICAL PROCEDURE CODE INDICATED AS ON REVIEW
177	SECONDARY SURGICAL PROCEDURE CODE INDICATED AS ON REVIEW
178	EXPECTED DATE OF DELIVERY MUST BE AT LEAST 30 DAYS FROM DATE OF CONSENT.
179	CLAIM DENIED-PLEASE RESUBMIT CLAIM WITH REPORT OF PROCEDURE PERFORMED.
180	DETAIL PROCEDURE INDICATE AS ON REVIEW.
181	RESUBMIT WITH FEDERAL STERILIZATION CONSENT FORM ATTACHED.
182	RESUBMIT W/OPERATIVE NOTES OR EXPLANATION OF PROCEDURE.
183	RESUBMIT W/HYSTERECTOMY CONSENT FORM ATTACHED.
184	RESUBMIT WITH MAP-235 OR MAP-236 ATTACHED IF APPROPRIATE.
185	CONSENT FORM MUST BE SIGNED BY MEMBER 30 DAYS PRIOR TO STERILIZATION
186	STERILIZATION MUST BE 180 DAYS OR LESS FROM DATE CONSENT SIGNED BY MEMBER.
187	STAMPED SIGNATURES ARE UNACCEPTABLE.
188	CLAIM DENIED. DOCUMENTATION NEEDED FOR CLAIM PROCESSING INCLUDES AUDIOLOGIST RECOMMENDATION, MEDICAL CLEARANCE STATEMENT, AND INVOICE.
189	CONSENT FORM MUST BE SIGNED AND DATED AT LEAST 72 HOURS PRIOR TO STERILIZATIONPROCEDURE IN CASES OF EMERGENCY SURGERY OR PREMATURE DELIVERY.
190	THE CLAIM DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM.
191	THE SECONDARY DIAGNOSIS IS INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM.

192	THIS DIAGNOSIS IS NOT COVERED FOR THE MEMBERS AGE.
193	THE SECONDARY DIAGNOSIS IS INVALID FOR THE MEMBER'S AGE.
194	DIAGNOSIS IS INVALID FOR MEMBER'S SEX.
195	THE SECONDARY DIAGONSIS IS INVALID FOR MEMBER SEX.
196	THE BILLED DIAGNOSIS IS ON REVIEW.
197	CLAIM/DETAIL DENIED. ROOT CANAL THERAPY LIMITED TO PERMANENT TEETH,
198	DATES OF SERVICE FOR THIS CLAIM TYPE MUST ALL BE FROM THE SAME MONTH.
199	CLAIM DETAIL DENIED. REVENUE CODE 360 MUST BE BILLED WITH A SURGICAL PROCEDURE CODE (01000 THROUGH 69999).
200	CLAIM/DETAIL DENIED. PROVIDER ON REVIEW FOR THIS DIAGNOSIS.
201	BILLING PROVIDER/NPI NUMBER IS MISSING.
202	INDIVIDUAL/CLINIC PROVIDER/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE.
203	CLAIM/DETAIL DENIED. PROCEDURE CODE MODIFIER AG OR TYPE OF SERVICE 7 OR B NOT ALLOWED FOR DATES OF SERVICE AFTER 12/12/94.
204	INVALID DIAGNOSIS CODE. CONTACT THE DEPARTMENT FOR MEDICAID SERVICES.
205	DIAGNOSIS CODE INVALID FOR PROVIDER TYPE
206	CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE.
207	DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE.
208	THIS PROCEDURE IS NOT COVERED FOR THIS DIAGNOSIS
209	CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE CODES BEGINING WITH 0.
210	CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW.
211	THIRD DIAGNOSIS CODE IS NOT ON FILE.
212	CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID.
213	THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM.
214	CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW.
215	CLAIM DENIED - AGE RESTRICTION FOR COVERED DIAGNOSIS
216	CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX.
217	THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE.
218	FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX.
219	FOURTH HEADER DIAGNOSIS ON REVIEW.
220	SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.
221	THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE.
222	THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE
223	THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE
224	CLAIM DENIED. MISSING OR INVALID DIAGNOSIS CODE.
225	NO HISTORY MATCH FOUND, PLEASE RESUBMIT.
226	CANNOT BEPROCESSED ON THIS CLAIM FORM.
227	CLAIM OVERLAPS YOUR FISCAL YEAR END.
228	THE PROVIDER IS NOT ELIGIBLE FOR DATE OF SERVICE.
229	BILLING PROVIDER NUMBER INVALID OR NOT ON PROVIDER FILE.
230	THE CLINIC IS NOT ELIGIBLE FOR THE CLAIM DATES OF SERVICE.
231	CLAIM/DETAIL DENIED. BILLING PROVIDER NAME DOES NOT MATCH THE NAME ON PROVIDER FILE.
232	CLAIM/DETAIL DENIED. PROVIDER IS ON PREPAYMENT REVIEW.
233	UPIN MISSING OR INVALID.
234	CLAIM/DETAIL DENIED. REFERRING PROVIDER FLAG SET TO SUSPEND FOR REVIEW.
235	SERVICE NOT PROVIDED UNDER THE MEDICAID PROGRAM.
236	PERFORMING PROVIDER NOT ASSOCIATED WITH THE BILLING PROVIDER.
237	CLAIM DENIED. CLINIC PROVIDER NUMBER NOT ON FILE.
238	CLAIM DENIED. BILLING PHYSICIAN/PROVIDER NOT LISTED AS MEMBER OF CLINIC.
239	DETAIL PROVIDER NUMBER INVALID OR NOT ON FILE.
240	MODIFIER 26 OR 50 CANNOT BE BILLED WITH THIS PROCEDURE CODE.
241	PENDING CONFIRMATION OF PROVIDER ELIGIBILITY.
242	NO LEVEL 2 PRICING RECORD FOUND FOR MODIFIERS TC OR 26.
243	PROCEDURE CODE Y2870 INVALID FOR DATES OF SERVICE 10/15/94 AND AFTER FOR THIS PROVIDER TYPE.
244	PROVIDER HAS NOT MET ALL REQUIREMENTS FOR BILLING OTHER LABORATORY AND X-RAY SERVICES.
245	THESE SERVICES MAY BE BILLED ONLY BY A MEMBER'S HOSPICE PROVIDER.
246	80022-ROUTINE VENIPUNCTURE SINGLE HOMEBOUND NURSING HOME OR SNF NOT ALLOWED SAME DOS/MEMBER/PROVIDER AS 80020-BLOOD COLLECTION VENIPUNCTURE.
247	PHYSICIAN ASSISTANT NUMBER MISSING/INVALID, NOT ELIGIBLE FOR THE DATE OF SERVICE, OR NOT LINKED TO AN INDIVIDUAL PHYSICIAN.
248	CLAIM DENIED. SURGEON AND ASSISTANT SURGEON BILLING NOT ALLOWED ON SAME FORM.
249	PAYMENT REDUCED BECAUSE OUR RECORDS SHOW MEMBER WAS NOT I N FACILITY FOR ALL OF THE TOTAL BILLED DAYS.
250	THIS MEMBER IS NOT ON OUR ELIGIBILITY FILE. PLEASE VERIFY MEMBER MAID NUMBER.
251	INCORRECT MEMBER IDENTIFICATION NUMBER.
252	MEMBER NAME ON CLAIM DOES NOT MATCH MEMBER NAME ON THE MEDICAID ELIGIBILITY DATABASE FOR THE MAID NUMBER SUBMITTED ON YOUR CLAIM.
253	OUR RECORDS INDICATE THE MEMBER WAS DECEASED PRIOR TO THE ENDING DATE OF SERVICE.
254	THE MEMBER IS NOT ELIGIBLE ON THE CLAIM SERVICE DATES.
255	MEMBER HAS MEDICARE PART B. PLEASE BILL MEDICARE FOR THESE SUPPLIES.
256	OUR RECORDS INDICATE THAT THIS MEMBER MAY BE ELIGIBLE FOR MEDICARE. PLEASE BILL MEDICARE FIRST. IF MEDICARE DENIES THIS SERVICE, RESUBMIT WITH PROOF OF DENAL.
257	OUR RECORDS INDICATE THAT THE MEMBER WAS OVER 21 YRS OLD ON THE DATE(S) OF SERVICE. THE MEMBER IS NOT ELIGIBLE FOR THE SERVICE(S).
258	MEDICARE SUSPECT/DENTAL.
259	THE MEMBER HAS MEDICARE PART B. PLEASE BILL MEDICARE.
260	CLAIM DENIED. THE KENTUCKY MEDICAL ASSISTANCE PROGRAM IS ONLY RESPONSIBLE FOR BUY-IN PREMIUMS FOR THIS MEMBER. MEDICAID CLAIMS ARE NOT REIMBURSIBLE FOR THS M
261	OUR RECORDS INDICATE THAT THE MEMBER WAS DECEASED PRIOR T O THE ENDING DATE OF SERVICE.
262	MEMBER IS NOT ELIGIBLE ON THE DATE OF SERVICE.
263	CLAIM DENIED. MEMBER NOT ELIGIBLE FOR PORTION OF DATES OF SERVICE.
264	MEMBER NAME IS MISSING.
265	INCORRECT MEMBER IDENTIFICATION NUMBER.
266	MEMBER NOT ELIGIBLE FOR WAIVER SERVICES.
267	WAIVER PAYMENT AMOUNT REDUCED DUE TO MEMBER CONTINUING INCOME
268	MEMBER MAID NUMBER ON CLAIM DOES NOT MATCH THE MEMBER MAID NUMBER ON ATTACHED ELIGIBILITY CARD.
269	CLAIM DENIED. TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO MEMBERS ENROLLED IN A WAIVER OR HOSPICE PROGRAM.
270	CLAIM DENIED. THIS SERVICE IS NOT PAYABLE FOR A MODEL WAIVER MEMBER.
271	CLAIM DENIED. MEMBER AVAILABLE INCOME INFORMATION NOT ON FILE FOR THE MONTH OFSERVICE. PLEASE CONTACT DMS AT 1-800-635-2570.
272	CLAIM/DETAIL DENIED. UNIT BILLED AMOUNT CANNOT BE GREATER THAN
273	CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO CERTAIN TOOTH NUMBERS.
274	MEMBER TREATMENT AUTHORIZATION INFORMATION NOT FOUND ON INPATIENT HOSPITAL FILE.
275	INPATIENT HOSPITAL TREATMENT AUTHORIZATION NUMBER MISSING OR INVALID.
276	DETAIL DENIED. THIS SERVICE NOT PAYABLE FOR EMPOWER NON-EMERGENCY TRANSPORTATION MEMBERS.
277	THE ATTACHED THIRD PARTY DOCUMENTATION IS NOT SUFFICIENT.CONTACT HPE PROVIDER BILLING INQUIRY FOR ASSISTANCE.
278	CLAIM DENIED. CLAIM/DOCUMENTATION INDICATES THIRD PARTY PAYMENT WAS RECEIVED BY MEMBER.
279	CLAIM/DETAIL INDICATES MEMBER HAS OTHER INSURANCE BUT NO INSURANCE AMOUNT ENTERED ON CLAIM.
280	CLAIM DENIED. YOUR CLAIM INDICATES THIS SERVICE IS DUE TO A WORK-RELATED ACCIDENT/INJURY. PLEASE BILL OTHER INSURANCE FIRST.
281	MEMBER HAS OTHER MEDICAL COVERAGE. BILL OTHER INSURANCE FIRST OR ATTACH DOCUMENTATION OF DENIAL FROM THE INSURANCE CARRIER.
282	THE MEMBER HAS MEDICARE PART A. PLEASE BILL MEDICARE.
283	OUR RECORDS INDICATE MEMBER HAS MEDICARE PART B, PLEASE BILL MEDICARE.
284	OUR RECORDS INDICATE THAT THIS MEMBER IS ELIGIBLE FOR HOSPICE COVERAGE BY MEDICARE. PLEASE BILL MEDICARE FIRST.
285	REGIONAL ANESTHESIA PROCEDURE CODES MAY NOT BE BILLED USING TYPE OF SERVICE 07, MODIFIER AG, OR MORE THAN ONE UNIT OF SERVICE PER DATE OF SERVICE.
286	THIS PROCEDURE CODE IS LIMITED TO ONE UNIT OF SERVICE PER DATE OF SERVICE.
287	PROFESSIONAL COMPONENT REVENUE CODE MUST BE BILLED WITH THE CORRESPONDING TECHNICAL COMPONENT REVENUE CODE.

288	PROFESSIONAL COMPONENT REVENUE CODE MUST BE BILLED WITH CORRESPONDING TECHNICAL REVENUE CODE. CHARGES MOVED TO NON-COVERED.
289	CLAIM DENIED. RENDERING PROVIDER NUMBER MISSING OR INVALID.
290	PENDING CONFIRMATION OF MEMBER ELIGIBILITY.
291	PENDING POSSIBLE OTHER INSURANCE INVOLVEMENT.
292	CLAIM SUSPENDED FOR BUY-IN ELIGIBILITY REVIEW.
293	CLAIM SUSPENDED FOR ELIGIBILITY REVIEW.
294	KENPAC MEMBER. REFERRING PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PRIMARY PHYSICIAN/CLINIC NUMBER FOR THE DATE(S) OF SERVICE.
295	BILLING OR REFERRING KENPAC PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PHYSICIAN/CLINIC FOR DATE(S) BILLED. KENPAC REFERRING PROVIDER NUMBER SHOULD BE EN
296	CLAIM DENIED. TYPE OF SERVICE DOES NOT MATCH PROCEDURE MODIFIER.
297	MEMBER IS NOT ELIGIBLE FOR HOSPICE.
298	MEMBER IS NOT ELIGIBLE FOR HOSPICE FOR BILLED DATES OF SERVICE.
299	HOSPICE MEMBER. OUR FILES SHOW MEMBER IS COVERED BY ANOTHER HOSPICE PROVIDER FOR BILLED DATE(S) OF SERVICE.
300	SERVICE PAYS ZERO FOR PRIMARY CARE AND RURAL HEALTH CLAIMS
301	CLAIM DENIED. RENDERING PROVIDER NOT LISTED AS A MEMBER OF THE BILLING GROUP.
303	THIS SERVICE MUST BE BILLED FOR A MINIMUM OF 8 UNITS PER DATE OF SERVICE.
304	OFFICE/EMERGENCY NOT COVERED SAME DATE OF SERVICE AS A NORPLANT/REMOVEL.
305	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS INVALID FOR THE PROVIDER PROFESSIONAL CODE (1ST DIGIT OF MODIFIER).
306	A HOSPICE MEMBER - RECYCLE FOR EDIT 298.
307	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS NOT PAYABLE UNLESS BILLED IN CONJUNCTION WITH OTHER DESIGNATED PROCEDURES.
308	DETAIL DENIED. REQUIRED DOCUMENTATION IS MISSING OR DOES NOT VERIFY THAT MEDICAL ASSISTANCE WAS PROVIDED.
310	CLAIM DENIED. NEW ADMISSION NOT PAYABLE BECAUSE OF NON-COMPLIANCE.
311	CORRECTED PAYMENT PER ADJUSTMENT REQUEST.
316	CLAIM/DETAIL PAID. CLAIMS HISTORY REFLECTS THE TOOTH NUMBER PREVIOUSLY EXTRACTED. PLEASE CHECK RECORDS AND VERIFY TOOTH NUMBER.
319	INCORRECT PROVIDER NUMBER SUBMITTED - PAYMENT DELAYED.
320	CLAIM DENIED. EXCEEDS THERAPY LIMITS FOR DRUG CLASS.
321	EPSDT SCREENING PROCEDURES ARE NOT PAYABLE WITHIN 30 DAYS OF AN EPSDT RELATED PROCEDURES.
322	EPSDT RELATED PROCEDURES ARE NOT PAYABLE WITHIN 30 DAYS OF AN EPSDT SCREENING PROCEDURES.
325	CLAIM/DETAIL DENIED. SCREENING PROCEDURE CODE INVALID FOR MEMBER'S AGE.
326	CLAIM DENIED. BILL/INVOICE MUST ACCOMPANY CLAIM.
327	PROCEDURE/NDC REQUIRES PRIOR AUTHORIZATION.
328	PRIMARY SURGICAL PROCEDURE REQUIRES PRIOR AUTHORIZATION.
329	SECONDARY SURGICAL PROCEDURE REQUIRES PRIOR AUTHORIZATION
330	DETAIL DENIED. DETAIL UNITS BILLED EXCEED UNITS PRIOR AUTHORIZED.
331	PAYMENT REDUCED BY AMOUNT PREVIOUSLY PAID. POST OP INCLUDED IN PROCEDURE.
333	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS REQUIRE PRIOR AUTHORIZATION.
334	SUPPLY NOT COVERED ON RENTAL ITEM.
335	LACKS REPORT TO JUSTIFY HIGHER FEE.
337	CATHETERIZATION PROCEDURES 80021,80023 AND 80024 NOT ALLOWED SAME DOS/MEMBER/PROVIDER.
340	ONLY THREE FOLLOW UP EXAMS ALLOWED DURING THE SIX MONTH PERIOD FOLLOWING THE FITTING OF A HEARING AID.
341	AN OFFICE VISIT, ER VISIT OR CONSULTATION ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS A HOSPITAL ADMISSION.
342	AN OFFICE VISIT AND/OR ER VISIT ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS A CONSULTATION.
343	CLAIM MASS ADJUSTED DUE TO A RETROACTIVE RATE CHANGE
344	AN OFFICE VISIT IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS AN EMERGENCY ROOM VISIT.
345	80020-BLOOD COLLECTION VENIPUNCTURE NOT ALLOWED SAME DOS/ MEMBER/PROVIDER AS 80022-ROUTINE VENIPUNCTURE SINGLE HOMEBOUND NURSING HOME OR SNF.
347	DENTURE RELATED EMERGENCY SERVICES AND UPPER OR LOWER DENTURE RELINE NOT PAYABLE ON SAME DATE OF SERVICE.
348	ROOM CHARGES REDUCED TO SEMI PRIVATE RATE.
349	EMERGENCY DENTAL PROCEDURES AND EXTRACTION PROCEDURES NOT PAYABLE ON SDOS.
350	DETAIL DENIED. FILLINGS ARE NOT PAYABLE FOR THE SAME TOOTH AND THE SAME DATE OF SERVICE AS EMERGENCY SERVICES OR SEALANTS.
351	INCORRECT NUMBER OF DAYS COVERED AND NON-COVERED.
352	CLAIM DENIED. INAPPROPRIATE PROCEDURE CODE USED.
353	INDIVIDUAL ALLERGY TESTING PROCEDURES ARE NOT PAYABLE WITH W0308-MAXIMUM ALLOWABLE PER ALLERGY TESTING OF SERVICE.
354	MANUAL PRICE INVALID OR NOT ACCOMPANIED BY A MANUAL PRICE EOB
355	FEE ADJUSTED TO MAXIMUM ALLOWABLE AMOUNT
356	CLAIM/DETAIL DENIED AFTER REVIEW BY MEDICAL CONSULTANTS.
357	CLAIM DENIED. INVOICE MUST HAVE ITEM BILLED NOTED.
359	REFER TO THE ADJUSTMENT REASON CODE.
360	FEE ADJUSTED PER CLAIM CREDIT.
361	GENERAL OPHTHALMOLOGICAL SERVICES NOT PAYABLE ON THE SAME DATE OF SERVICE AS SPECIAL OPHTHALMOLOGICAL SERVICES.
362	PATIENT LIABILITY APPLIED TO ALLOWED AMOUNT FOR THIS CLAIM.
363	ROOT REMOVAL NOT PAYABLE ON SAME DATE OF SERVICE AS THE TOOTH EXTRACTION
364	PAYMENT REDUCED BY OTHER INSURANCE
365	FEE ADJUSTED TO MAXIMUM ALLOWABLE.
366	CLAIM DENIED. BILLED AMOUNT MAY NOT EXCEED $50.00 PER UNIT OF SERVICE.
367	THIS SERVICE PAID COINSURANCE AND/OR DEDUCTIBLE.
368	REIMBURSEMENT RATE RECORD NOT FOUND FOR PROVIDER.
369	ORIGINAL PSYCHIATRIC EVALUATION AND REGULAR HOSPITAL ADMISSION NOT PAYABLE ON SAME DATE OF SERVICE.
370	PAYMENT MODE NOT FOUND FOR BILLING PROVIDER
371	REIMBURSEMENT RATE NOT FOUND FOR DATE OF SERVICE
372	HOSPITAL FOLLOW-UP VISITS AND ORIGINAL PSYCHIATRIC DIAGNOSTIC EVALUATION AND/OR FOLLOW-UP PSYCHIATRIC CARE ARE NOT ALLOWED FOR SAME DATE OF SERVICE.
373	UNITS OF SERVICE HAVE BEEN REDUCED TO THE REMAINING PRIOR AUTHORIZED QUANTITY.
374	REPAYMENT PORTION OF THIS ADJUSTMENT HAS BEEN DENIED. RECOUPMENT IS UNDER FINANCIAL ITEMS.
375	KYCONV-DESCRIPTION NOT FOUND
376	CLAIM DENIED. MAC FIELD INVALID.
377	MEMBER INCOME/PATIENT LIABILITY DEDUCTION NOT APPLICABLE FOR THIS CLAIM.
378	CLAIM DETAIL DENIED. THIS PROCEDURE CODE IS NOT COVERED.
379	PAID BY MEDICAID
380	CO-PAY WAS DEDUCTED FROM REIMBURSEMENT.
381	CERTAIN SPECIFIED PROCEDURES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE AS EMERGENCY ROOM VISIT
382	DETAIL DENIED. BILLED AMOUNT FOR IMPLANTABLES MUST BE GREATER THAN $100.00.
383	CERTAIN INCIDENTAL SURGERIES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE AS ABDOMINAL SURGERY.
384	DETAIL DENIED. INVOICE MUST BE ATTACHED WHEN BILLING IMPLANTABLES.
385	CERTAIN INCIDENTAL PROCEDURES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE AS A D.& C. PROCEDURE.
386	DETAIL DENIED. INVOICE AMOUNT MUST MATCH BILLED AMOUNT.
387	CERTAIN INCIDENTAL SURGERIES AND PELVIC SURGERIES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE.
388	THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE ANCILLARY REVENUE CODE (240). CHARGES MOVED TO NON-COVERED.
389	PAID CLAIM BASED UPON MEDICAL REVIEW.
390	CLAIM DENIED. DUPLICATE SERVICE BILLED.
391	DETAIL DENIED. PROCEDURE CODES X0091/97535 AND X0103/S5140 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X0061/T2016, X0088/S5126, OR X0089/H0043.
392	DETAIL DENIED. PROCEDURE CODES X0061, X0088, AND X0089 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X0091.
393	CLAIM DENIED. THE PRIMARY DIAGNOSIS CODE IS NOT VALID FOR THIS PROVIDER TYPE.
394	HOURLY RESPITE SERVICES NOT ALLOWED FOR SAME DATE OF SERVICE AS DAILY RESPITE SERVICES.
395	THE AMOUNT PAID BY OTHER INSURANCE EQUALS OR EXCEEDS THE AMOUNT OF MEDICAID REIMBURSEMENT FOR THIS SERVICE. THE CLAIM IS PAID IN FULL. MEMBER SHALL NOT BEBIL
396	DAILY RESPITE SERVICES NOT ALLOWED FOR SAME DATE OF SERVICE AS HOURLY RESPITE SERVICES.
397	ACCOMMODATION REVENUE CODES MUST BE BILLED ON AN INPATIENT CLAIM.
398	CLAIM/DETAIL DENIED. THE PROCEDURE CODE MODIFIER IS MISSING OR INVALID.
399	CLAIM/DETAIL DENIED. THIS SERVICE NOT COVERED FOR THIS PE MEMBER.

403	PLEASE GIVE THE DATE(S) OF SURGERY AND RETURN THE INVOICE TO THIS OFFICE.
404	NURSING FACILITY PRIOR AUTHORIZATION NOT ON FILE - RECYCLE FOR EDIT 332.
409	INVALID PROVIDER TYPE BILLED ON CLAIM FORM.
410	FORMAT INVALID FOR ELECTRONIC CLAIMS. PLEASE CONTACT ECS HELP DESK AT 1-800-205-4696.
411	DUE TO THE END OF YOUR FISCAL YEAR, PLEASE REBILL THESE MULTIPLE MONTHS OF SERVICE ON SEPARATE INVOICES - ONE INVOICE FOR EACH MONTH.
412	DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL.
413	MEMBER NOT ENROLLED IN MANAGED CARE DURING DATES OF SERVICE.
414	MEMBER ENROLLED IN MANAGED CARE DURING DATES OF SERVICE.
415	FFS CLAIM HAS A MANAGED CARE PROVIDER TYPE.
416	CAPITATION RATE NOT WITHIN DATES OF SERVICE.
417	CLAIM DENIED. INVALID OR MISSING CAPITATION INDICATOR.
418	CLAIM DENIED. INVALID ENCOUNTER TYPE.
419	CLAIM DENIED. INVALID ENC RECEIPT DATE.
420	CLAIM DENIED. INVALID ENC PAYMENT AMOUNT.
421	CLAIM DENIED. INVALID ENC PAYMENT DATE.
422	CLAIM DENIED. INVALID ENC ADJUSTMENT TCN.
423	CLAIM DENIED. INVALID MEMBER NOT ELIG FOR PHYSICAL.
424	CLAIM DENIED. INVALID MEMBER NOT ELIG FOR BEHAVIORAL.
425	DETAIL DENIED. PROCEDURE CODE NOT A COVERED SERVICE.
426	THE 36 MONTH MAXIMUM FOR THIS SERVICE HAS BEEN EXCEEDED. THE
427	CLAIM DENIED. RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM WITH JUSTIFICATION FOR DUPLICATED SERVICE.
428	FFS NOT ALLOWED, MEMBER ELIGIBLE FOR BEHAVIORAL HEALTH MANAGED CARE.
429	CLAIM DENIED. PARTNERSHIP NUM MISMATCH
430	CLAIM DENIED. ENCOUNTER, INV. TCN TO CREDIT
431	RESERVED FOR MANAGED CARE.
432	CLAIM DENIED. SEQ# MISMATCH ACROSS CLAIM.
433	CLAIM DENIED. VOID/RESUB INVALID FOR XOVER.
434	RESERVED FOR MANAGED CARE.
435	CLAIM/DETAIL DENIED. SCL WAIVER SERVICES ARE ONLY PAYABLE TO THE PRIMARY SCL PROVIDER FOR THIS MEMBER.
436	CLAIM DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO 1 UNIT PER MEMBER, PER FIVE YEARS.
437	CLAIM DENIED. CERTAIN OUTPATIENT HOSPITAL CHARGES ARE NOT PAYABLE WITHIN 3 DAYS PRIOR TO AN INPATIENT HOSPITAL ADMISSION (AND VICE VERSA).
438	CLAIM DETAIL DENIED. PROCEDURE CODE 90853 IS LIMITED TO 6 UNITS PER DAY, PER MEMBER, PER PROVIDER.
439	CLAIM DETAIL DENIED. PROCEDURE CODE 90853 IS LIMITED TO 12 UNITS PER CALENDAR WEEK, PER MEMBER, PER PROVIDER.
440	CLAIM/DETAIL DENIED. REVENUE CODE 582 LIMITED TO 4 UNITS PER CALENDAR WEEK (SUNDAY THROUGH SATURDAY).
441	CLAIM/DETAIL DENIED. PROCEDURE CODES 99244 AND 99245 ARE LIMITED CUMULATIVELY TO ONE UNIT PER DAY PER MEMBER.
442	CLAIM/DETAIL DENIED. THIS PROCEDURE CODES IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS PROCEDURE CODES 99244 AND 99245.
443	CLAIM/DETAIL DENIED. PROCEDURE CODES 99244 AND 99245 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS CERTAIN OTHER TITLE V PROCEDURE CODES.
444	PLEASE CORRECT INVALID OR MISSING NDC NUMBER.
445	CLAIM/DETAIL DENIED. PROCEDURE CODE 99244 IS LIMITED TO ONE PER FIVE YEARS, PER MEMBER, PER PROVIDER.
446	CLAIM/DETAIL DENIED. PROCEDURE CODE 99245 IS LIMITED TO ONE PER FIVE YEARS, PER MEMBER, PER PROVIDER.
447	CLAIM/DETAIL DENIED. X0079 LIMITED TO 8 UNITS PER DAY.
448	MEMBER NOT ON ELIGIBILITY FILE - SUSPEND FOR EDIT 250.
449	THE MEMBER ELIGIBILITY MAID NUMBER ON THE MEDICAID CARD ATTACHED WITH YOUR CLAIM IS INCORRECT.
450	CLAIM DETAIL DENIED. ASSESSMENT PROCEDURES ARE LIMITED TO ONE (1) PER MEMBER, PER PROVIDER DURING THE MEMBER'S ASSESSMENT PERIOD ON THE PRIOR AUTHORIZAION FI
451	CLAIM DETAIL DENIED. UNABLE TO APPLY ASSESSMENT PROCEDURE LIMITATION DUE TO NO CASE MANAGEMENT ON PRIOR AUTHORIZATION FILE. CONTACT PRO.
452	CLAIM/DETAIL DENIED. X0080/H0004 LIMITED TO 12 UNITS PER WEEK.
453	CLAIM/DETAIL DENIED. X0061/T2016, X0088/S5126, X0089/H0043, AND X0103/S5140 LIMITED TO 1 UNIT, CUMULATIVELY, PER DAY.
454	CLAIM/DETAIL DENIED. X0079/H0039 LIMITED TO 32 UNITS PER DAY.
455	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY.
456	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY.
457	CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATIVELY, PER DAY.
458	CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO $150.00 PER DAY.
459	CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CALENDAR YEAR.
460	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY.
461	CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK.
462	PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX.
463	PAY TPL CLAIM.
464	PAY AND BILL TPL CLAIM.
465	MEMBER COVERED BY PRIVATE INSURANCE (NO ATTACHMENT).
466	DETAIL DENIED. EARLY INTERVENTION AND CERTAIN EPSDT-SPECIAL SERVICES PROCEDURES ARE NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THE SAME MEMBER.
467	MEMBER HAS OTHER MEDICAL COVERAGE. BILL OTHER INSURANCE FIRST OR ATTACH DOCUMENTATION OF DENIAL FROM THE INSURANCE CARRIER.
469	CLAIM/DETAIL DENIED. COMPANION CARE UNITS ARE LIMITED TO 200 PER WEEK.
472	MEMBERS LIMITED TO ONE DRUG CLASS(GPPC) 681200 PRISCRIPTION/REFILL PER DATE OF SERVICE.
473	MEDICAID REIMBURSEMENT FOR THIS DATE OF SERVICE HAS ALREADY BEEN MADE. CLAIM PAYMENT SET TO ZERO.
476	MEMBER IN AN INSTITUTIONAL SETTING DURING THE SAME DATE OF SERVICE.
477	MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATES OF SERVICE.
478	YOUR FACILITY HAS PREVIOUSLY BILLED AND RECEIVED PAYMENT FOR ALL OR A PORTION OF THESE DATES OF SERVICE.
479	CLAIM DENIED. SERVICES FOR THESE DATES OF SERVICE HAVE BEEN PAID TO A NON-HOSPICE PROVIDER.
481	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.
482	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.
483	DUPLICATE ANESTHESIA SERVICE BILLED BY PHYSICIAN AND NURSE ANESTHETIST.
484	ONLY ONE ANESTHESIA ALLOWED PER DOS PER MEMBER.
486	DETAIL PLACE OF SERVICE NOT COVERED THROUGH THE PODIATRY PROGRAM.
487	ROUTINE FOOT CARE IS NOT PAYABLE FOR THIS DIAGNOSIS.
489	CLAIM DENIED. THIS SERVICE WAS PREVIOUSLY PAID TO ANOTHER PROVIDER.
490	CONSECUTIVE OUTPATIENT SERVICES ARE NON-PAYABLE DURING A HOSPITAL INPATIENT STAY.
491	CLAIM DENIED. MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATES OF SERVICE.
492	CLAIM/DETAIL DENIED. DCBS MEMBERS MAY NOT RECEIVE TITLE V SERVICES AND IMPACT PLUS/CHMC SERVICES ON THE SAME DATE OF SERVICE.
493	CLAIM/DETAIL DENIED. DCBS MEMBERS MAY NOT RECEIVE THE SAME DCBS MENTAL HEALTH SERVICES FROM TWO DIFFERENT SUB-PROVIDERS ON THE SAME DATE OF SERVICE.
494	DETAIL DENIED. THIS SERVICE IS NOT PAYABLE BEYOND THE BIRTH MONTH OF THE MEMBER'S 18TH BIRTHDAY.
496	ONLY ONE (1) ANESTHESIA\IV SEDATION ALLOWED PER DATE OF SERVICE PER MEMBER.
497	CLAIM/DENIED. RESUBMIT AN ADJUSTMENT ON HPE ADJUSTMENT REQUEST FORM.
498	CLAIM DENIED. ONLY ONE PAYMENT ALLOWED PER MEMBER, PER DATE OF SERVICE.
499	CLAIM PENDING REVIEW OF HISTORY.
500	CLAIM DENIED. BIFOCAL OR SINGLE VISION LENSES LIMITED TO TWO SETS PER 12 MONTHS.
501	PROFESSIONAL FEE-DISPENSING SERVICE ALLOWED ONE PER 12 MONTHS PER MEMBER.
502	ONE FAMILY PLANNING SERVICE PER DOS.
503	ANNUAL FAMILY PLANNING VISITS LIMITED TO 1 PER MEMBER PER NINE MONTHS PER CLINIC.
504	FAMILY PLANNING MEMBERS LIMITED TO ONE INITIAL VISIT PER PROVIDER PER THREE YEAR PERIOD.
505	MEMBER IN INSTITUTIONAL SETTING DURING SAME DATE OF SERVICE.
506	CBC AND COMPONENTS NOT ALLOWED SAME DOS.
507	PACKAGE OF 12 TESTS AND COMPONENTS NOT ALLOWED SAME DOS.
508	COMPLETE BLOOD COUNT AND COMPONENTS NOT ALLOWED SAME DOS.
509	MEMBERS ARE LIMITED ON INITIAL AND FOLLOW UP VISITS TO ONE PER YEAR PER PROVIDER FOR DOS PRIOR TO SEPT. 1, 1985.
510	MEMBERS LIMITED ON SELECTED INITIAL AND FOLLOW UP VISITS TO 1 PER DATE OF SERVICE.
511	PAYMENT FOR REVISION OF ARTERIOVENOUS SHUNT IS INCLUDED IN FEE FOR INITIAL INSERTION WHEN REVISION IS PERFORMED WITHIN 21 DAYS OF ORIGINAL PROCEDURE.

512	CLAIM DENIED. FOLLOW UP VISIT INCLUDED IN REIMBURSEMENT FOR DELIVERY.
513	CLAIM DENIED. FOLLOW-UP HOSPITAL VISITS INCLUDED IN REIMBURSEMENT FOR C-SECTION.
514	CAST APPLICATION/REMOVAL INCLUDED IN REIMBURSEMENT FOR SURGERY.
515	CLAIM DENIED CULTURES/SMEARS NOT ALLOWED SAME DOS FOR SAME CONDITION.
516	EXTRACTION OR EXPOSURE OF TOOTH DISALLOWED IF PREVIOUSLY EXTRACTED OR EXPOSED.
517	CLAIM DENIED. EMERGENCY SERVICES LIMITED TO ONE PER DOS PER MEMBER PER PROVIDER.
518	CLAIM/DETAIL DENIED. INITIAL TOOTH EXTRACTION LIMITED TO ONE PER DOS/MEMBER/PROVIDER. USE PROCEDURE 07120 FOR EACH ADDITIONAL TOOTH EXTRACTED
519	CLAIM DENIED. REIMBURSEMENT FOR CIRCUMCISION WITHIN TEN DAYS OF DELIVERY IS INCLUDED IN DELIVERY FEE.
520	MAINTENANCE DRUG DAYS SUPPLY LESS THAN 30 DAYS.
521	COMPREHENSIVE CLIENT RE-EVALUATION NOT ALLOWED WITHIN 12 MONTHS OF COMPREHENSIVE CLIENT EVALUATION.
522	COMPREHENSIVE CLIENT RE-EVALUATION LIMITED TO ONCE PER LIFE TIME.
523	RESIDENTIAL COMPONENT SERVICE NOT ALLOWED WITH IN-HOME SCL SERVICES ON THE SAME DOS.
524	IN-HOME SCL SERVICES NOT ALLOWED WITH RESIDENTIAL COMPONENT SERVICES ON THE SAME DOS.
525	IN-PATIENT MEMBERS ARE LIMITED TO ONE ATTENDANCE AND ONE CONSULTATION PER ADMISSION.
526	IN-PATIENT MEMBERS WHO HAVE HAD ORAL SURGERY ARE LIMITED TO 1 ATTENDANCE AND/OR 1 CONSULTATION PER DATE OF SERVICE PER PROVIDER.
527	ADDITIONAL SERVICES TO THE SAME TOOTH ARE DISALLOWED IF THE TOOTH HAS BEEN PREVIOUSLY EXTRACTED.
528	ADDITIONAL SERVICES TO THE SAME TOOTH ARE DISALLOWED ON THE SAME DOS AS A CROWN PROCEDURE OR A FRACTURED INCISAL BUILD-UP.
529	CROWN AND BUILD UP PROCEDURES ARE DISALLOWED IF ADDITIONAL DENTAL SERVICES HAVE BEEN PAID FOR THE SAME TOOTH SAME DOS.
530	CLAIM PAID. CLAIM HAS BEEN REDUCED BY THE AMOUNT OF THE DISPENSING FEE.
531	PURCHASE UNITS BILLED EXCEEDS MAXIMUM ALLOWED FOR THIS PRIOR AUTHORIZATION CHECK YOUR MAP-9 FORM.
532	RENTAL UNITS/CHARGES BILLED EXCEEDS MAXIMUM ALLOWED FOR THIS PRIOR AUTHORIZATION CHECK YOUR MAP-9 FORM.
533	CLAIM DENIED. PRIOR AUTHORIZATION NOT ON FILE OR DOES NOT MATCH CLAIM INFORMATION.
534	CLAIM DENIED. PROCEDURE CODE X0064 CANNOT BE BILLED IN CONJUNCTION WITH OTHER PROCEDURE CODES.
535	PLEASE BILL BABY'S HOSPITAL STAY AFTER MOTHER'S DISCHARGE ON SEPARATE CLAIM FORM, USING BABY'S OWN NAME AND NUMBER.
536	THE MEDICARE EOMB INDICATES THIS IS A DUPLICATE BILLING. PLEASE SUBMIT THE ORIGINAL EOMB INDICATING THE DEDUCTIBLE AND CO-INSURANCE AMOUNTS.
537	CLAIM/DETAIL DENIED. THIS PROCEDURE SHALL NOT BE PAID SEPARATELY WHEN THE GLOBAL SERVICE HAS BEEN REPORTED. CONTACT THE DEPT. FOR MEDICAID SERVICES FOR CLARI
538	CLAIM/DETAIL DENIED. THIS PROCEDURE REQUIRES PRIOR AUTHORIZATION. NO
539	CLAIM/DETAIL DENIED. EPSDT RELATED SERVICES CLAIM EXCEEDS TOTAL UNITS OF SERVICE PRIOR AUTHORIZED.
540	HOME HEALTH NURSING VISITS NOT REIMBURSED WHEN PRIVATE DUTY NURSING HAS BEEN AUTHORIZED THROUGH EPSDT SPECIAL SERVICES.
541	CAST APPLICATION OR REMOVAL HAS BEEN PAID SEPARATE OF SURGERY. PLEASE RESUBMITFOR ADJUSTMENT WITH PAID RA OF CAST APPLICATION OR REMOVAL AND CORRECTED CLAIM
542	DETAIL DENIED. IMPLANTABLES ARE LIMITED TO TWO UNITS OF SERVICE PER PROCEDURE, PER MEMBER, PER 90 DAYS.
543	MULTIPLE SURGERIES FOR SAME DATE OF SERVICE MUST BE BILLED ON SAME CLAIM. YOUR CLAIM IS DENIED AND INSTRUCTIONS FOR SUBMITTING AN ADJUSTMENT ARE BEING FORWAR
544	CLAIM/DETAIL DENIED. TELEHEALTH SERVICES ARE LIMITED TO 12 PER MEMBER PER 12 MONTHS.
545	MULTIPLE MEDICAL/SURGICAL PROCEDURES FOR THE SAME DATE OF SERVICE MUST BE BILLED ON SAME CLAIM. FILE AN ADJUSTMENT TO ADD ADDITIONAL PROCEDURES TO RELATED PA
546	CLAIM/DETAIL DENIED. PRESCRIPTION NUMBER REFILL DATE IS GREATER THAN SIX (6) MONTHS OLD.
547	CLAIM PAYMENT REDUCED. SPEND DOWN DEDUCTED.
548	CLAIM/DETAIL DENIED. REVENUE CODE 235 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155, 183, AND/OR 185.
549	CLAIM/DETAIL DENIED. THIS PROCEDURE SHALL NOT BE PAID SEPARATELY WHEN THE GLOBAL SERVICE HAS BEEN REPORTED. CONTACT THE DEPT. FOR MEDICAID SERVICES FOR CLARI
550	PROCEDURE CODE 00140/D0140 CAN ONLY BE BILLED ALONE OR WITH MONITORED PROCEDURE CODES FOR THE SAME MEMBER, SAME PROVIDER, AND SAME DATE OF SERVICE.
551	DISPENSING FEE DEDUCTED. IT WAS PAID WITH DISPENSING OF THE EMERGENCY SUPPLY.
552	THE STAY DAYS BILLED EXCEEDS THE MAXIMUM NUMBER OF STAY DAYS FOR THIS INPATIENT HOSPITAL STAY.
553	CLAIM DENIED. DRUG REQUIRES PRIOR AUTHORIZATION OR FIRST LINE THERAPY INITIATED.
554	THE DATE OF SERVICE AND/OR DOLLAR AMOUNTS ON THE CLAIM AND MEDICARE EOMB DO NOT AGREE. PLEASE VERIFY AND RESUBMIT.
555	PLEASE ATTACH THE PART B MEDICARE EXPLANATION OF BENEFITS AND REBILL.
556	CLAIM/DETAIL DENIED. MEMBER MUST BE AN INPATIENT IN THE NURSING FACILITY.
557	CLAIM DENIED. SECOND LINE ANTIHISTAMINE NOT PAYABLE WITHIN FIVE DAYS OF A FIRST LINE ANTIHISTAMINE.
558	CLAIM DETAIL DENIED. H0039 LIMITED TO 32 UNITS PER DAY.
559	CLAIM DENIED. THIS CLAIM EXCEEDS THE MONTHLY MAXIMUM UNITS FOR THIS NDC.
560	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.
567	CLAIM DENIED. NO WAIVER LIABILITY BUCKET FOR MONTH OF SERVICE.
568	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED. .
569	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.
570	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.
571	CLAIM DENIED. PRIOR AUTHORIZATION REQUIRED IF 30 DAYS OF THERAPY EXCEEDED DURING A 365 DAY PERIOD.
572	DETAIL DENIED. LEAD INVESTIGATION IN THE HOME LIMITED TO TWO (2) SERVICES PERSIX MONTHS.
573	DETAIL DENIED. POST HAZARD ABATE IN HOME LIMITED TO ONE (1) SERVICE PER 12 MONTHS.
574	CLAIM DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.
575	REVENUE CODE INVALID FOR DATES OF SERVICE.
576	ANCILLARY CHARGES NOT ALLOWED WITH PATIENT REVENUE CODES 180 OR 185.
577	CLAIM DETAIL DENIED. PROCEDURE CODES X0100/H0043 AND X0101/T2016 CANNOT BE BILLED ON THE SAME DATE OF SERVICE FOR THE SAME MEMBER BY THE SAME OR DIFFERENTPRO
578	CLAIM DENIED. PRIOR AUTHORIZATION REQUIRED IF 60 DAYS OF THERAPY EXCEEDED DURING A 3 YEAR PERIOD.
579	CLAIM/DETAIL DENIED. REVENUE CODE 581 LIMITED TO 80 UNITS PER MEMBER PER CALENDAR WEEK (SUNDAY THROUGH SATURDAY).
580	CLAIM/DETAIL DENIED. THE ANNUAL LIMITATION OF $1000.00 PER MEMBER FOR MINOR HOME ADAPTATIONS HAS BEEN EXCEEDED.
581	CLAIM/DETAIL DENIED. UNIVERSAL PREVENTION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF EIGHT UNITS PER MEMBER, PER PREGNANCY.
582	CLAIM/DETAIL DENIED. SELECTIVE PREVENTION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 76 UNITS PER MEMBER, PER PREGNANCY.
583	CLAIM/DETAIL DENIED. INDICATED PREVENTION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 108 UNITS PER MEMBER, PER PREGNANCY.
584	CLAIM/DETAIL DENIED. CERTAIN OUTPATIENT SERVICES PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 32 UNITS PER MEMBER, PER CALENDAR WEEK (SUNDAY THRU SAURD
585	CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT NON-RESIDENTIAL SERVICES PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 28 UNITS PER MEMBER, PER DAY.
586	CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT NON-RESIDENTIAL SERVICES PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 160 UNITS PER MEMBER, PER CALENDAR WEEK
587	CLAIM/DETAIL DENIED. DAY REHABILITATION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 8 UNITS PER MEMBER, PER DAY.
588	CLAIM/DETAIL DENIED. DAY REHABILITATION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 45 UNITS PER MEMBER, PER CALENDAR WEEK (SUNDAY THRU SATURDAY).
589	CLAIM/DETAIL DENIED. SUBSTANCE ABUSE COMMUNITY SUPPORT NOT PAYABLE UNLESS BILLED IN CONJUNTION WITH SUBSTANCE ABUSE CASE MANAGEMENT (DATES OF SERVICE WITHIN0
590	HOSPITAL OUTPATIENT SERVICES NON-PAYABLE DURING A HOSPITAL INPATIENT STAY.
591	CLAIM/DETAIL DENIED. OUTPATIENT THERAPIES INDIVIDUAL, GROUP, AND FAMILY PROCEDURE CODES ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS INTENSIVE OUTPATIENT S
592	CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT SERVICES NON-RESIDENTIAL AND DAY REHABILITATION PROCEDURE CODES ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS OUTPA
593	CLAIM DENIED. THIS PROCEDURE IS NOT PAYABLE UNLESS BILLED IN CONJUNTION WITH WB505, WB516, WB526/90862(UD), WB507, WB521, WB602/90804(UD), WB508, WB522, WB60
594	CLAIM DENIED. CLAIM EXCEEDS 140 DAY ACID/PEPTIC THERAPY LIMITATION.
596	CLAIM DETAIL DENIED. OFFICE VISITS NOT ALLOWED WITHIN 10 DAYS FOLLOWING A SURGICAL PROCEDURE.
597	CLAIM/DETAIL DENIED. THIS PROCEDURE IS NOT PAYABLE AFTER THE DATE OF DELIVERY.
598	CLAIM DETAIL DENIED. ONLY ONE 'E AND M' CODE ALLOWED PER DATE OF SERVICE.
599	CLAIM PENDING REVIEW OF HISTORY.
600	EYE EXAM LIMITED TO OPTOMETRIST.
601	ONLY 3 FOLLOW UP EXAMS ARE ALLOWED PER 6 MONTHS.
602	CLAIM DENIED. LIMIT 2 ROUTINE ORTHODONTICS PER MEMBER PER 12 MONTHS
603	CLAIM DENIED. EACH MEMBER ALLOWED ONE FULL MOUTH RADIOGRAPHY EVERY 2 YEARS PER PROVIDER.
604	NOT MORE THAN TWO (2) COMPONENT TESTS OF A CBC ARE ALLOWED PER MEMBER ON THE SAME DATE OF SERVICE.
605	ONLY FOUR MENTAL HEALTH/SUBSTANCE ABUSE PROCEDURES ALLOWED PER YEAR, PER PROVIDER, PER MEMBER.
606	PIN RETENTION CAN ONLY BE BILLED ALONE OR WITH MONITORED PROCEDURE CODES FOR THE SAME MEMBER, SAME PROVIDER, SAME DATE OF SERVICE, AND SAME TOOTH NUMBER.
607	EACH MEMBER ALLOWED 4 SINGLE BITEWING X-RAYS PER 12 MONTHS PER PROVIDER.
608	CLAIM DENIED. THIS SERVICE IS LIMITED TO ONE PER MEMBER, PER PROVIDER,PER CALENDAR MONTH.
609	CLAIM DENIED. ONE DENTAL PROPHYLAXIS/FLOURIDE TREATMENT PER MEMBER PER 12 MONTH PERIOD.
610	CLAIM DENIED. EACH MEMBER ALLOWED ONE UPPER TRANSITIONAL APPLIANCE PER 12 MONTHS.
611	MEMBER ALLOWED THREE TRANSITIONAL APPLIANCE REPAIRS PER 12 MONTHS.
612	ONLY 9 UNITS (ADULT DAY HABILITATION) ALLOWED PER DATE OF SERVICE PER MEMBER.
613	RESIDENTIAL RESPITE DAILY SERVICE ALLOWED FOR ONLY 30 CONSECUTIVE DAYS.
614	MEMBER ALLOWED ONLY 30 CONSECUTIVE DAY OF IN-HOME RESPITE DAILY SERVICE.

615	MAXIMUM OF 40 DAYS RESIDENTIAL RESPITE COMBINING DAILY AND HOURLY SERVICES PER MEMBER PER CALENDAR YEAR.
616	MAXIMUM OF 60 DAYS IN-HOME RESPITE ALLOWED COMBINING DAILY AND HOURLY SERVICES PER MEMBER PER CALENDAR YEAR.
617	MEMBER ALLOWED 1 INITIAL OFFICE VISIT WITH COMPLETE DIAGNOSIS PER 9 MONTHS.
618	ONLY ONE DELIVERY ALLOWED PER MEMBER/9 MOS.
619	MEMBER ALLOWED POST-PARTUM CARE 2 TIMES PER YEAR.
620	CLAIM DENIED. MAXIMUM DAILY DOSE EXCEEDED - PRIOR AUTHORIZATION REQUIRED.
621	DETAIL DENIED. MAXIMUM DOLLAR AMOUNT FOR COMMUNITY BASED SERVICES RESPITE SERVICE HAS BEEN EXCEEDED.
622	DETAIL DENIED. ANNUAL LIMIT OF $500.00 FOR MINOR HOME ADAPTIONS.
623	MEMBER ALLOWED 14 SINGLE INTRAORAL PERIAPICAL RADIOGRAPHS PER 12 MOS PER PROVIDER.
624	CLAIM DENIED. THIS PROCEDURE ALLOWED ONE PER DOS PER TOOTH PER PROVIDER.
625	CLAIM DENIED/MEMBER ALLOWED 3 REPAIRS INCLUDING REPLACEMENTS OF ONE TOOTH PER 12 MONTHS.
626	CLAIM DENIED. ONLY 14 DAYS SERVICE ALLOWED PER ADMISSION PER MEMBER.
627	CLAIM DENIED. MEMBER ALLOWED 3 REPAIRS TO BROKEN DENTURES PER 12 MONTHS.
629	MEMBER ALLOWED 1 LOWER TRANSITIONAL APPLIANCE PER 12 MONTHS.
631	MEMBERS ARE LIMITED TO ONE DENTURE RELINING PER 12 MONTHS.
632	FULL MOUTH DEBRIDEMENT IS ALLOWED ONCE PER MEMBER PER PREGNANCY.
633	CLAIM DENIED. BRAND NECESSARY PRIOR AUTHORIZATION REQUIRED. NO MATCHING BRAND NECESSARY PRIOR AUTHORIZATION ON FILE FOR THIS CLAIM.
634	MAXIMUM $300.00 ALLOWED PER MONTH/MEMBER FOR TANK OXYGEN.
635	AIS/MR DAILY CODE LIMITED TO ONE UNIT PER DATE OF SERVICE PER MEMBER.
636	PROFESSIONAL FEE FOR DISPENSING INITIAL PAIR OF EYEGLASSES ALLOW ONE / 12 MOS /MEMBER.
637	CLAIM DENIED. MEMBER LIMITED TO 3 FETAL TESTS/12 MONTHS. IF UNUSUAL CIRCUMSTANCES, SEND CLAIM DOCUMENTATION TO DMS FOR REVIEW.
638	ANNUAL FAMILY PLANNING VISITS ARE LIMITED TO ONE PER MEMBER PER 9 MONTHS PER CLINIC.
640	THIS DETAIL WAS MANUALLY PRICED AFTER REVIEW BY CONSULTANTS.
641	PRIOR AUTHORIZATION DOES NOT MATCH FOR THIS CLAIM/DETAIL.
642	THIS PROCEDURE IS LIMITED TO ONE PER 12 MONTHS PER MEMBER PER PROVIDER.
644	MEMBERS ARE LIMITED TO ONE (1) OPTHAMOLOGICAL EXAMINATION PER PROVIDER PER 12 MONTHS.
645	NEW PATIENT HOME MEDICAL SERVICES LIMITED TO ONE PER MEMBER PER PROVIDER PER 12 MONTHS.
646	ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO ONE PER MEMBER PER PROVIDER PER 12 MONTHS.
648	MEMBER ARE LMTD ON INITIAL PREVENTATIVE CARE VISITS TO 1 PER PROV PER 12 MONTHS.
649	MEMBER LMTD 1 INITIAL OPTHALMOLOGICAL SERVICE PER PROV PER 12 MONTHS.
650	ROUTINE NEWBORN CARE IS PAYABLE ONLY ONCE PER INFANT.
652	CLAIM DENIED. BIFOCAL OR SINGLE VISION LENSES ARE LIMITED TO FOUR PER 12 MONTHS.
653	CLAIM/DETAIL DENIED. A PRESCRIPTION CAN ONLY BE BILLED 6 TIMES.
654	MEMBER ALLOWED FILLINGS FOR UP TO FIVE SURFACES PER TOOTH PER DOS PER PROVIDER.
655	MAXIMUM OF 14 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER.
656	MAXIMUM OF 15 NON-HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER CALENDAR YEAR.
657	MAXIMUM OF 45 HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER CALENDAR YEAR.
658	MAXIMUM OF 15 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER.
659	MAXIMUM OF 30 CONSECUTIVE RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER.
660	MAXIMUM OF 45 RESERVE DAYS PER MEMBER PER PROVIDER PER CALENDAR YEAR.
661	CLAIM DENIED. READMISSION WITHIN 14 DAYS OF LAST DISCHARGE DATE/THROUGH DATE. PLEASE RESUBMIT WITH DOCUMENTATION NECESSITATING READMISSION ALONG WITH BOTH DIS
662	A MAXIMUM OF 14 INPATIENT HOSPITAL DAYS PER ADMISSION AND READMISSION PER MEMBER.
665	VENIPUNCTURE/CATHETERIZATION PROCEDURES 80020,80022,80023, 80024,36415 NOT ALLOWED SAME DOS/MEMBER/PROVIDER.
666	CLAIM/DETAIL DENIED. PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED OR NON-MICROSCOPY LAB CODE.
667	THIS PROCEDURE IS LIMITED TO ONE SERVICE PER MEMBER PER SAME DATE OF SERVICE.
668	DAY CARE SERVICES ARE LIMITED TO NO MORE THAN 2 UNITS OF SERVICE PER DATE OF SERVICE.
669	DAYS REDUCED, A MAXIMUM OF 14 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER,PER PROVIDER.
670	DAYS REDUCED, A MAXIMUM OF 15 NON-HOSPITAL RESERVE DAYS ALLOWED PER MEMBER,PER PROVIDER,PER CALENDAR YEAR.
671	CLAIM/DETAIL DENIED. MEDICAID WILL PAY FOR ONLY ONE CARDIAC CATHETER PROCEDURE PER DAY.
673	CLAIM DENIED. CPT LEVEL CODE MISSING OR INVALID.
674	PROCEDURE CODE V5020 IS LIMITED TO THREE PER MEMBER PER PROVIDER PER SIX MONTHS.
675	CLAIM DETAIL DENIED. PROCEDURE CODE W0030 IS LIMITED TO ONE UNIT PER MEMBER, PER PROVIDER, PER 60 DAYS.
676	PROCEDURE W0030/V5011 CAN ONLY BE PERFORMED 150 TO 210 DAYS 5 TO 7 MONTHS AFTER PERFORMING PROCEDURE V5090.
677	PROCEDURE CODE LIMITED TO ONE PER 60 DAYS.
678	MEMBERS ARE LIMITED TO A MAXIMUM OF 10 MONTHLY STABILIZATION VISITS DURING PHASE I TREATMENT CONTACT DMS FOR FURTHER CONSIDERATION.
679	CLAIM/DETAIL DENIED. ONLY ONE HANDS PROCEDURE CODE ALLOWED PER MEMBER PER DATE OF SERVICE.
680	FAMILY AND/OR GROUP PSYCHOTHERAPY LMTD TO ONE PER DATE OF SERVICE.
681	CLAIM DENIED. THIS HOSPITALIZATION IS RELATED TO A PREVIOUSLY PAID ADMISSION.
682	CLAIM DENIED. REIMBURSEMENT CANNOT EXCEED A MAXIMUM OF 14 DAYS PER ADMISSION.
683	MODEL WAIVER MEMBERS ARE LIMITED TO 16 HOURS OF NURSING/ RESPIRATORY SERVICES PER DATE OF SERVICE.
684	MODEL WAIVER RESPIRATORY SERVICES ARE LIMITED TO ONE UNIT PER MEMBER PER DATE OF SERVICE.
685	CLAIM/DETAIL DENIED. A HOSPICE SERVICE HAS BEEN PAID FOR SAME MEMBER/SAME DATE(S) OF SERVICE.
686	CLAIM/DETAIL DENIED. HOSPICE RESPITE SERVICES ARE LIMITED TO FIVE CONSECUTIVE DAYS PER MEMBER.
687	UNITS BILLED EXCEED MAXIMUM FOR THIS PRIOR AUTHORIZATION.
688	MODEL WAIVER DOLLAR LIMIT HAS BEEN MET.
689	MEMBERS ARE LIMITED TO A MAXIMUM OF 365 ORAL CONTRACEPTIVE UNITS PER 12 MONTH PERIOD.
690	CLAIM DENIED. TARGETED CASE MANAGEMENT SERVICES ARE LIMITED TO 1 PER CALENDAR MONTH, PER MEMBER.
691	CLAIM/DETAIL DENIED. CLIA ID MISSING OR INVALID.
692	CLAIM/DETAIL DENIED. PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED LAB CODE.
693	COMPREHENSIVE ORTHODONTIC EXAM LIMITED TO ONE PER MEMBER PER 12 MONTHS.
694	COMPREHENSIVE ORTHODONTIC EXAM LIMITED TO TWO (2) PER MEMBER PER LIFETIME.
695	MEMBERS ARE LIMITED TO A MAXIMUM OF 24 MONTHLY RETENTION VISITS PER LIFETIME.
696	CLAIM/DETAIL DENIED. PROFESSIONAL COMPONENT CHARGES MUST BE BILLED ON HCFA-1500.
697	MEMBERS ARE LIMITED TO ONE RETENTION VISIT PER 30 DAYS.
698	MEMBERS ARE LIMITED TO A MAXIMUM OF 10 POST TREATMENT STABILIZATION VISITS PER LIFETIME.
699	CLAIM/DETAIL DENIED. PROCEDURE CODE T2022 IS LIMITED TO $260.00 IN
700	CLINIC PROVIDER IS INELIGIBLE FOR THIS CATEGORY OF SERVICE.
701	CLAIM DENIED. BED RESERVE REVENUE CODES FOR MENTAL HOSPITAL AND ACUTE PSYCHIATRIC BED ARE LIMITED TO A COMBINATION OF 14 UNITS PER CALENDAR YEAR PER MEMBERIE
702	CLAIM DENIED. BED RESERVE/OTHER REVENUE CODE IS LIMITED TO A TOTAL OF 21 UNITS PER CALENDAR 6 MONTHS PER MEMBER, PER PROVIDER.
703	CLAIM DENIED. BED RESERVE/ACUTE REVENUE CODE IS LIMITED TO A TOTAL OF 14 UNITS PER CALENDAR YEAR, PER MEMBER, PER PROVIDER.
704	CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY CLAIMS ARE LIMITED TO 30 CONSECUTIVE BED RESERVE DAYS PER MEMBER, PER PROVIDER.
705	NEW PATIENT OPHTHALMOLOGICAL SERVICES LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS/THREE YEARS.
706	NEW PATIENT OFFICE OR OUTPATIENT SERVICES LIMITED TO ONE PER MEMBER, PER PRO VIDER, PER 36 MONTHS/THREE YEARS.
707	NEW PATIENT HOME MEDICAL SERVICES LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS/THREE YEARS.
708	NEW PATIENT PREVENTATIVE CARE VISITS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS/THREE YEARS.
709	CLAIM/DETAIL DENIED. PROCEDURE CODE 70320 LIMITED TO ONE PER YEAR, PER MEMBER, PER PROVIDER.
710	CLAIM/DETAIL DENIED. ONLY ONE (1) CHEMOTHERAPY ADMIN CODE IS PAYABLE ON THE SAME DATE OF SERVICE. IF QUESTIONS, PLEASE CONTACT THE DEPARTMENT FOR MEDICAID S
711	PROVIDER NOT APPROVED FOR ELECTRONIC BILLING SUBMIT MAP 380 PROVIDER AGREEMENT FORM.
712	CLAIM/DETAIL DENIED. PROCEDURE CODE T2022 IS LIMITED TO $265.00 PER CALENDAR MONTH.
713	DELIVERY, ROUTINE NEWBORN CARE, CIRCUMCISION ARE LIMITED TO ONE EACH PER MEMBER PER DATE OF SERVICE.
715	CLAIM DENIED. PROCEDURE CODE X0064 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER, PER MEMBER, PER TWO YEARS.
716	CLAIM DENIED. PROCEDURE CODE X0074 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER, PER MEMBER, PER TWO YEARS.
717	CLAIM DENIED. PROCEDURE CODE X0075 LIMITED TO A TOTAL OF 76 UNITS OF SERVICE PER PROVIDER, PER MEMBER, PER TWO YEARS.
718	CLAIM DENIED. PROCEDURE CODE X0076/T2022 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER, PER MEMBER, PER CALENDAR MONTH.
719	CLAIM DENIED. A MAXIMUM OF 60 RESPITE DAYS (COMBINING DAILY AND HOURLY SERVICES) ALLOWED PER PROVIDER, PER MEMBER, PER CALENDAR YEAR.
722	CLAIM/DETAIL DENIED. BUCCAL AND FACIAL TOOTH SURFACES NOR OCCLUSAL AND INCISAL TOOTH SURFACES NOT ALLOWED FOR SAME MEMBER, SAME PROVIDER, SAME DATE OF SERICE

723	CLAIM/DETAIL DENIED. ONLY FOUR TOOTH SURFACES ALLOWED PER MEMBER, PER PROVIDER, PER DATE OF SERVICE, PER TOOTH NUMBER.
724	CLAIM DETAIL DENIED. HOME MODIFICATIONS ARE LIMITED TO $1000.00 IN PAYMENTS PERSIX MONTHS.
725	INDIVIDUAL PSYCHOTHERAPY IS LIMITED TO 12 UNITS OF SERVICE PER DAY,PER MEMBER,PER PROVIDER.
726	CLAIM/DETAIL DENIED. CEPHALOMETRIC X-RAY LIMITED TO ONE PER MEMBER, PER PROVIDER, EVERY TWO YEARS.
727	CLAIM/DETAIL DENIED. DIALYSIS TRAINING LIMITED TO ONE (1) PER MEMBER, PER LIFETIME.
728	GINGIVECTOMY PROCEDURE IS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER TOOTH NUMBER PER 12 MONTHS.
729	PIN RETENTION THERAPY TREATMENT IS LIMITED TO TWO PER MEMBER PER PERMANENT MOLAR PER LIFETIME.
730	PROCEDURE CODE 07880/D7880 LIMITED TO ONE PER LIFETIME PER MEMBER.
731	MEMBERS ARE LIMITED TO ONE RELINING OF THE LOWER DENTURE PER 12 MONTHS.
732	ALVEOPLASTY PROCEDURE CODES ARE LIMITED TO ANY COMBINATION OF THESE PROCEDURES WITH ONLY ONE PER QUADRANT, PER MEMBER, PER LIFETIME.
733	PROCEDURES ARE LIMITED TO ANY COMBINATION OF THESE PROCEDURES WITH ONLY ONE EACH PER QUADRANT, PER MEMBER, PER 12 MONTH PERIOD, PER PROVIDER.
734	CLAIM/DETAIL DENIED.PROCEDURE IS NOT ALLOWED TO THE SAME TOOTH ON THE SAME DATE OF SERVICE AS A SEALANT.
735	CLAIM/DETAIL DENIED. SYRINGES LIMITED TO 125 UNITS PER 26 DAYS, PER MEMBER.
736	CLAIM/DETAIL DENIED. VACCINE ADMINISTRATION LIMITED TO (3) PER MEMBER, PER PROVIDER, PER DATE OF SERVICE.
737	CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO ONE PER TOOTH PER FOUR YEARS PER MEMBER.
738	CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO THREE PER TOOTH PER LIFETIME PER MEMBER.
739	CLAIM/DETAIL DENIED. SEALANTS ARE NOT ALLOWED TO A TOOTH THAT HAS RECEIVED AN OCCLUSAL FILLING.
740	CLAIM/DETAIL DENIED. ONLY ONE UNIT OF SERVICE ALLOWED FOR THIS DENTAL PROCEDURE PER PRIOR AUTHORIZATION.
741	CLAIM DENIED. MEMBER LIMITED TO 2 DIAGNOSTIC ULTRASOUNDS PER 9 MONTHS. MEDICAL NECESSITY MUST SUPPORT UNUSUAL CIRCUMSTANCES. DIAGNOSIS CODE MUST INDICATEMED
742	DETAIL DENIED. INTRAORAL COMPLETE SERIES LIMITED TO ONE UNIT PER MEMBER, PER PROVIDER, PER 12 MONTHS.
743	GINGIVECTOMY LIMITED TO 1 UNIT PER TOOTH, PER 12 MONTHS, PER MEMBER, PER PROVIDER.
744	CLAIM/DETAIL DENIED. SCHOOL-BASED HEALTH SERVICES ARE LIMITED TO 40 UNITS OF SERVICE PER DATE OF SERVICE. PLEASE CHECK THE UNITS OF SERVICE BILLED FOR ERRORS
745	CLAIM/DETAIL DENIED. PROCEDURE CODE X0058 CANNOT BE BILLED BY A SCHOOL BASED PROVIDER AND A COMMUNITY MENTAL HEALTH PROVIDER ON THE SAME DATE OF SERVICE.
746	REVENUE/PROCEDURE CODE INVALID FOR PROVIDER TYPE.
747	CLAIM DETAIL DENIED. PROCEDURE CODES X0079/H0039 AND X0098/97537, (ANY COMBINATION) ARE LIMITED TO FORTY HOURS PER CALENDAR WEEK.
748	REVENUE/PROCEDURE CODE INVALID FOR PLACE OF SERVICE.
749	CLAIM DETAIL DENIED. RESPITE CARE IS LIMITED TO 168 HOURS PER SIX MONTHS.
750	DRUG/DRUG INTERACTION.
751	REVENUE/PROCEDURE CODE INVALID FOR DATE OF SERVICE.
752	REVENUE CODE MISSING/INVALID.
753	INVALID REVENUE CODE. CHARGES NOT ALLOWED.
754	EARLY REFILL.
755	NON-REIMBURSABLE FOR THIS PROVIDER TYPE/DOS. EFFECTIVE FOR DOS 10/01/90 AND AFTER, DRUGS MUST BE BILLED BY MEDICAID PARTICIPATING PHARMACY.
756	CLIA ID MISSING OR INVALID. CHARGES MOVED TO NON-COVERED.
757	CHARGES MOVED TO NON-COVERED. RTSUP CAN ONLY BE REIMBURSED WHEN CHARGES FOR RTARE BILLED FOR THE SAME DATES OF SERVICE.
758	PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED LAB CODE. CHARGES MOVED TO NON-COVERED.
759	PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED OR NON-MICROSCOPY LAB CODE. CHARGES MOVED TO NON-COVERED.
760	INFERRED DRUG/DISEASE PRECAUTION.
761	DRUG/AGE PRECAUTION.
762	MEDICAL CONDITION ALERT.
763	SERVICES RENDERED DO NOT MEET DMS CRITERIA
764	DIAGNOSIS AND DESCRIPTION OF TREATMENT ARE REQUIRED FOR SERVICES RENDERED.
765	THERAPEUTIC DUPLICATION.
766	REVENUE CODE PROCEDURE CODE COMBINATION INVALID. CHARGES MOVED TO NON-COVERED.
767	INGREDIENT DUPLICATION.
768	ALCOHOL PRECAUTION.
769	BREAST FEEDING PRECAUTION.
770	DRUG/FOOD INTERACTION.
771	DRUG/LAB CONFLICT.
772	CALL HELP DESK (1-800-807-1232).
773	INVALID DUR CONFLICT CODE.
774	INVALID DUR INTERVENTION CODE.
775	INVALID DUR OUTCOME CODE.
777	CLAIM DENIED. PHARMACY CLAIMS MUST BE BILLED THROUGH POS.
778	VARIANCE LIMIT MET. CLAIM PENDING REVIEW.
781	CLAIM/DETAIL DENIED. THE MEMBER'S ANNUAL SPEECH THERAPY VISIT LIMIT
782	CLAIM/DETAIL DENIED. THE MEMBER'S ANNUAL PHYSICAL THERAPY VISIT LIMIT
783	FULL MOUTH DEBRIDEMENT NOT ALLOWED ON SAME DATE OF SERVICE AS PROPHY OR
784	PROPHY OR PERIODONTAL SCALING AND ROOT PLANNING NOT ALLOWED ON SAME DATE
785	CLAIM/DETAIL DENIED. ONLY ONE DENTAL VISIT ALLOWED PER MEMBER PER
786	CLAIM/DETAIL DENIED. CAST PROCEDURES ARE LIMITED TO TWO PER 90 DAYS PER
788	CLAIM/DETAIL DENIED. ADULT DAY TRAINING IS LIMITED TO FIVE (5) DAYS PER
789	CLAIM/DETAIL DENIED. ADULT DAY TRAINING ON-SITE IS LIMITED TO EIGHT (8)
790	CLAIM/DETAIL DENIED. ADULT DAY TRAINING IS LIMITED TO 255 DAYS PER
791	CLAIM DETAIL DENIED. REVENUE CODE 580 IS LIMITED TO 45 UNITS (HOURS) PER WEEK (SUNDAY THROUGH SATURDAY).
792	CLAIM DETAIL DENIED. ONLY ONE OBSTETRICAL VISIT ALLOWED IN AN EIGHT WEEK PERIOD.
793	CLAIM DETAIL DENIED. ONLY ONE COMPREHENSIVE VISIT ALLOWED EVERY 50 WEEKS.
794	CLAIM/DETAIL DENIED. EPIDURAL INJECTIONS FOR CONTROL OF PAIN SHALL BE LIMITED TO 3 INJECTIONS PER 6 MONTHS PER MEMBER.
795	CLAIM/DETAIL REQUIRES PRIOR AUTHORIZATION. THE MONTHLY (CALENDAR MONTH) LIMITATION FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED.
796	CLAIM/DETAIL REQUIRES PRIOR AUTHORIZATION. THE ANNUAL (CALENDAR YEAR) LIMITATION FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED.
797	THE ANNUAL MAXIMUM FOR THIS SERVICE HAS BEEN EXCEEDED. THE ALLOWED
798	PROCEDURE CODE XZ299 IS LIMITED TO $150.00 PER CALENDAR MONTH PER MEMBER, PER PROVIDER.
799	REVENUE CODE 270 CANNOT EXCEED $2,000 BILLED AMOUNT PER MONTH. PLEASE RESUBMIT WITH ITEMIZED INVOICE FOR SUPPLIES FOR ENTIRE MONTH.
800	CLAIM DENIED. PROCEDURE CODES X0074 AND X0075 NOT PAYABLE ON SAME DATE OF SERVICE AS X0076.
801	CLAIM DENIED. PROCEDURE CODE X0076 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X0074 OR X0075.
802	PROCEDURE CODE 00150/D0150 DISALLOWED BY SAME PROVIDER FOR SAME MEMBER ON THE SAME DATE OF SERVICE AS PROCEDURES 09110/D9110 OR 00140/D0140.
803	MEMBER APPLIED INCOME NOT CURRENT FOR DOS - RECYCLE FOR EDIT 271.
808	MONTHLY DIALYSIS PROCEDURE CODES ARE NOT REIMBURSEABLE FOR THE SAME OR OVERLAPPING DATE OF SERVICE AS DAILY DIALYSIS PROCEDURE CODES.
809	DATE PRESCRIBED IS MISSING
810	HEMODIALYSIS PROCEDURE CODES ARE NOT REIMBURSABLE FOR THE SAME OR OVERLAPPING DATES OF SERVICE AS EVALUATION AND MANAGEMENT PROCEDURE CODES.
811	NDC IS MISSING
812	ADDITIONAL SURGICAL PROCEDURES ARE NOT PAYABLE ON SAME DATE OF SERVICE BY SAME PROVIDER FOR SAME MEMBER WHEN BILLING FOR SUTURE OF WOUND.
813	QUANTITY DISPENSED IS INVALID.
814	MEMBER ID NUMBER IS INVALID.
815	CLAIM DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE ON THE SAME DATE OF SERVICE AS COMMUNITY RESIDENTIAL SERVICES.
816	CAST REMOVAL OR REPAIR HAS BEEN PAID WITH APPLICATION OF CAST. IF UNRELATED PROCEDURES, SEND CLAIM WITH DOCUMENTATION OF UNRELATED PROCEDURES TO THE DMS FOR R
818	VENIPUNCTURE OR ARTERIAL PUNCTURE IS NOT ALLOWED ON THE SAME DATE OF SERVICE AS OTHER MONITORED PROCEDURES.
820	BILLING OR REFERRING KENPAC PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PHYSICIAN/CLINIC FOR DATE(S) BILLED. KENPAC REFERRING PROVIDER NUMBER SHOULD BE E
821	CLAIM DETAIL DENIED. LIMITATION EXCEEDED, PRIOR AUTHORIZATION REQUIRED.
822	X-RAY PROCEDURE NOT ALLOWED WITHIN 12 MONTHS OF INTRAORAL COMPLETE SERIES.
824	DETAIL DENIED. PROCEDURE CODE 08670 NOT PAYABLE WITHIN 24 MONTHS OF CERTAIN OTHER PROCEDURE CODES IF BILLED FOR THE SAME MEMBER BY THE SAME PROVIDER.
825	DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE WITHIN 24 MONTHS OF ORTHODONTIC TREATMENT IF BILLED FOR THE SAME MEMBER BY THE SAME PROVIDER.
826	PROCEDURE CODE 09110/D9110 NOT PAYABLE IF PAYMENT HAS BEEN MADE FOR OTHER DENTAL PROCEDURE CODES FOR THE SAME DATE OF SERVICE.
827	THIS PROCEDURE CODE IS NOT PAYABLE IF PAYMENT HAS BEEN MADE FOR PROCEDURE CODE 09110/D9110 FOR THE SAME DATE OF SERVICE.
828	CLAIM/DETAIL DENIED. THIS REVENUE CODE IS NOT PAYABLE FOR THIS PROVIDER SPECIALTY CODE.
829	CLAIM/DETAIL DENIED. PROVIDER NOT ELIGIBLE TO RECEIVE PAYMENT FOR SERVICES PROVIDED TO KCHIP PHASE III MEMBERS.

830	CLAIM DENIED. NO DRG FOUND.
831	CLAIM DENIED. DRG CANNOT USE DIAGNOSIS CODE.
832	CLAIM DENIED. DRG CRITERIA NOT MET.
833	CLAIM DENIED. DRG INVALID AGE.
834	CLAIM DENIED. DRG INVALID SEX.
835	CLAIM DENIED. DRG INVALID DISCHARGE STATUS.
836	CLAIM DENIED. DRG INVALID PRINCIPLE DIAGNOSIS.
837	CLAIM DENIED. DRG DENY 469 THROUGH 470.
838	PROCEDURE CODE T2033 LIMITED TO ONE UNIT PER DAY PER MEMBER
839	RESERVED FOR DRG
840	PROCEDURE CODE HAS BEEN REBUNDLED.
841	BYPASS INDICATOR, GMIS INFORMATIONAL ONLY.
842	PROCEDURE CODE IS MUTUALLY EXCLUSIVE.
843	PROCEDURE CODE IS INCIDENTAL.
844	PROCEDURE CODE IS NOT INDICATED FOR SEPARATE REIMBURSEMENT.
845	VISIT IS WITHIN ONE DAY PRE OP RANGE.
846	PROCEDURE CODE INCLUDES UNILATERAL AND BILATERAL PERFORMANCE.
847	PROCEDURE IS A BILATERAL OR DUPLICATE
848	PLEASE PAY SPECIFIED PROCEDURE CODES.
849	PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON.
850	PROCEDURE CODE IS INVALID FOR PATIENTS AGE.
851	PROCEDURE CODE IS INVALID FOR PATIENTS SEX.
852	INAPPROPRIATE PROCEDURE CODE FOR MEMBER'S AGE.
853	PEDIATRIC PROCEDURE AGE SHOULD BE 1 TO 17 YEARS
854	MATERNITY PROCEDURE AGE SHOULD BE 12 - 55 YEARS.
855	KYCONV-DESCRIPTION NOT FOUND
856	PROCEDURE IS INVALID FOR THE MEMBER'S GENDER.
857	PROCEDURE NOT INDICATED FOR A FEMALE
858	CLAIM DENIED. COSMETIC PROCEDURE.
859	CLAIM DENIED. DUPLICATE PROCEDURE.
860	CLAIM DENIED. EXPERMENTAL PROCEDURE.
861	CLAIM DENIED. OBSOLETE PROCEDURE.
863	PROCEDURE CODES DOES NOT REQUIRE AN ASSTANT SURGEON
864	PROCEDURE CODE IS INVALID FOR LOCATION.
865	PROCEDURE CODE NEEDS TO BE REPLACED.
866	PROCEDURE NEEDS TO BE REPLACED FOR SURFACES BILLED.
867	PROCEDURE CODE NEEDS TO BE REPLACED FOR SURFACES BILLED.
868	CLAIM/DETAIL DENIED. PURCHASE OF PROCEDURE CODES E0607 AND E2100 IS LIMITED TOONE PER FOUR YEARS.
873	CLAIM/DETAIL DENIED. EYEWARE LIMITATION OF $400.00 PER CALENDAR YEAR HAS
874	CLAIM/DETAIL DENIED. EYEWARE LIMITATION OF $200.00 PER CALENDAR YEAR HAS
875	CLAIM/DETAIL DENIED. PROSTHETIC DEVICE LIMITATION OF $1500.00 PER
876	CLAIM/DETAIL DENIED. HEARING AIDS ARE LIMITED TO $800.00 PER EAR, PER
877	CLAIM/DETAIL DENIED. CHILDREN'S DENTAL PROPHYLAXIS AND FLOURIDE
878	CLAIM/DETAIL DENIED. THE 12-MONTH LIMIT FOR DENTAL PROPHYLAXIS
879	PROCEDURE REQUIRES DOCUMENTATION
880	CLAIM DENIED. PROCEDURE CODE IS FOR PATIENTS UP TO AGE 14
881	CLAIM DENIED. PROCEDURE CODE IS FOR PATIENTS OVER AGE 14.
882	CLAIM DENIED. COSMETIC PROCEDURE NOT PAYABLE BY MEDICAID
883	CLAIM DENIED. DUPLICATE PROCEDURE HAS BEEN PAID.
884	CLAIM DENIED PROCEDURE IS CONSIDERED EXPERIMENTAL
885	CLAIM DENIED. PROCEDURE IS CONSIDERED OBSOLETE.
886	INAPPROPRIATE PROCEDURE CODE BILLED.
888	VISIT IS WITHIN THE POST-OP RANGE.
889	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS NOT PAYABLE IF BILLED WITH A SUBSTANCE ABUSE DIAGNOSIS CODE.
890	CLAIM/DETAIL DENIED. THIS PROCEDURE IS NOT PAYABLE IF BILLED WITHOUT ONE OF THE DESIGNATED PREGNANCY DIAGNOSIS CODES.
891	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE IF BILLED WITHOUT ONE OF THE DESIGNATED SUBSTANCE ABUSE DIAGNOSIS CODES.
893	UNITS OF SERVICE GREATER THAN THE REMAINING PRIOR AUTHORIZED AMOUNT.
894	DETAIL DENIED. THE PRIOR AUTHORIZED AMOUNT FOR THIS PROCEDURE HAS BEEN MET.
896	CLAIM HAS FAILED MORE THAN 24 ERROR CODES. PLEASE CORRECT AND RESUBMIT.
897	CLAIM DENIED TO PROVIDER NUMBER 99999997 FOR REBATCH OR RETURN REASONS.
898	TOO MANY CLAIMS IN A CYCLE.
899	DENIED PER PROVIDER REQUEST.
900	THE RX NUMBER MUST BE COMPLETED TO PROCESS YOUR CLAIM. PLEASE COMPLETE AND RESUBMIT YOUR CLAIM.
901	DRUG QUANTITY IS REQUIRED. COMPLETE THE MISSING INFORMATION AND RESUBMIT YOUR CLAIM.
902	CLAIM DENIED. DRUG QUANTITY BILLED FOR ESTABLISHED MINIMUM/ MAXIMUM QUANTITIES.
903	CLAIM DENIED. DRUG DAYS SUPPLY MISSING OR INVALID.
904	CLAIM DENIED. NDC IS RATED DESI FOR CLAIM DATE OF SERVICE.
905	CLAIM CREDIT QUANTITY MUST BE EQUAL TO OR LOWER THAN ORIGINAL CLAIM QUANTITY, PLEASE RESUBMIT.
906	PRESCRIBING PROVIDER'S LICENSE NUMBER MISSING INVALID OR NOT ON KY MEDICAID FILE.
907	CLAIM DENIED. NDC IS TERMINATED OR OBSOLETE.
908	CLAIM\DETAIL IS DENIED. THE MEMBER IS IN A NURSING FACILITY ON THE DATE OF SERVICE.
909	CLAIM DETAIL DENIED. ANCILLARY SERVICES NOT AUTHORIZED BY THE PRO.
910	CLAIM DENIED. SUBMITTED LEVEL OF CARE SERVICES NOT AUTHORIZED BY THE PRO.
911	MODIFIER INVALID FOR PROCEDURE CODE BILLED.
912	CLAIM DENIED. OUTPATIENT HOSPITAL CLAIMS FOR MORE THAN 2 DAYS ARE NOT ALLOWED.
913	CLAIM DENIED. OUTPATIENT HOSPITAL CLAIMS FOR MORE THAN TWO DAYS ARE NOT ALLOWED.
914	CLAIM DENIED. HEADER COVERED DAYS GREATER THAN THE 14 DAY MAXIMUM ALLOWED.
915	CLAIM/DETAIL DENIED. THE NON-COVERED AMOUNT CANNOT BE GREATER THAN THE BILLED AMOUNT.
916	EPSDT SPECIAL SERVICES/SCHOOL BASED HEALTH SERVICES CLAIMS NOT PAYABLE FOR THIS MEMBER.
917	CLAIM/DETAIL DENIED. SCREENING PROCEDURE CODE INVALID FOR MEMBER'S AGE.
918	CLAIM/DETAIL DENIED. THE DETAIL DATES OF SERVICE ARE NOT EQUAL TO OR WITHIN THE HEADER DATES OF SERVICE.
919	DETAIL DENIED. THIS SERVICE IS NOT PAYABLE BEYOND THE BIRTH MONTH OF THE MEMBER'S 21ST BIRTHDAY.
920	CLAIM DENIED. A PRESCRIPTION CAN ONLY BE BILLED 12 TIMES.
921	CLAIM DENIED. THIRD PARTY LIABILITY AMOUNT IS EQUAL TO MEDICARE PAID AMOUNT OR GREATER THAN HEADER COINSURANCE PLUS HEADER DEDUCTIBLE.
922	THIS SERVICE WAS NOT PAID BY MEDICARE. MEDICAID PAYMENT CAN ONLY BE MADE FROM A PAID MEDICARE EOMB.
923	CLAIM DENIED. A NINE-BYTE, ALL-NUMERIC TAX ID-NUMBER MUST BE ENTERED IN THE PATIENT'S ACCOUNT NUMBER FIELD ON THE CLAIM.
924	CLAIM DENIED. DISPROPORTIONATE SHARE HOSPITAL CLAIMS WHICH SPAN A MEMBER'S 6THBIRTHDAY MUST BE SPLIT BILLED. PLEASE REFER TO THE BILLING INSTRUCTIONS IN YOURP
925	CLAIM/DETAIL DENIED. VENIPUNCTURE AND ARTERIAL PUNCTURE NOT ALLOWED ON SAME DATE OF SERVICE AS OTHER MONITORED PROCEDURES.
926	CLAIM/DETAIL DENIED. THIS SERVICE NOT PAYABLE ON THE SAME DATE OF SERVICE AS VENIPUNCTURE AND ARTERIAL PUNCTURE.
927	CLAIM DENIED. THE CLINIC NUMBER MUST BE ENTERED.
928	DETAIL DENIED. A VALID 5-DIGIT MODIFIER MUST BE ENTERED.
929	CLAIM/DETAIL DENIED. ANESTHESIA LIMITED TO ONE PER MEMBER PER PROVIDER PER DATE OF SERVICE.
930	CLAIM/DETAIL DENIED. MEMBER HAS THIRD PARTY LIABILITY (MEDICARE REPLACEMENT POLICY) COVERAGE ON FILE.
931	CLAIM DENIED. COMPOUND CODE MISSING OR INVALID.
932	CLAIM/DETAIL DENIED. ONE DIALYSIS SERVICE ALLOWED PER RECIPIENT, PER PR
933	CLAIM DENIED. UNIT DOSE INDICATOR MISSING OR INVALID.

934	CLAIM DENIED DUE TO TRANSITION TO NEW SYSTEM. PLEASE RESUBMIT CLAIM.
935	DRUG INCOMPATABILITY ALERT.
936	CLAIM DENIED. MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATE(S) OF SERVICE.
937	CLAIM DENIED. PRESCRIPTION NUMBER REFILL DATE IS GREATER THAN ONE YEAR OLD.
938	CLAIM/DETAIL DENIED. MAXIMUM OF TEN NON-HOSPITAL RESERVE DAYS ALLOWED
939	CLAIM/DETAIL DENIED. MAXIMUM OF 14 HOSPITAL RESERVE DAYS ALLOWED PER
941	CLAIM DENIED. CURRENT PROVIDER LICENSE NOT ON FILE.
942	CLAIM DENIED. REVENUE CODE 129 IS NOT VALID WITH ANY OTHER ACCOMMODATION REVENUE CODE.
943	CLAIM/DETAIL DENIED. FRAMES OR COMPONENTS OF FRAMES ARE LIMITED TO 2
944	LOW DOSE ALERT.
945	HIGH DOSE ALERT.
946	LATE REFILL.
947	MINIMUM DURATION ALERT.
948	MAXIMUM DURATION ALERT.
949	DRUG ALLERGY ALERT.
950	CLAIM DENIED. THIS SERVICE IS NOT PAYABLE FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY MEMBERS.
951	THIS SERVICE IS NOT COVERED BY MEDICAID.
952	REIMBURSEMENT FOR THIS SERVICE IS INCLUDED IN THE TOTAL PAYMENT AMOUNT.
953	CLAIM DETAIL DENIED. ONLY ONE UNIT OF SERVICE ALLOWED PER MODIFIER.
954	CLAIM DETAIL DENIED. THE PROCEDURE CODE MODIFIER IS MISSING OR INVALID.
955	CLAIM/DETAIL DENIED. PROVIDER SPECIALITY INVALID FOR MODIFIER GT.
956	THIS PROFESSIONAL CANNOT BILL THIS PROCEDURE CODE.
957	CMHC PROCEDURES X0054 OR X0152 PAYABLE ONLY WHEN BILLED WITH ANOTHER CMHC PROCEDURE CODE
958	EFFECTIVE WITH DATES OF SERVICE ON OR AFTER 070193, A FIVE- DIGIT MODIFIER MUST BE BILLED ON COMMUNITY MENTAL HEALTH CENTER CLAIMS.
959	PRIOR ADVERSE DRUG REACTION.
960	THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE ACCOMMODATION REVENUE CODE 100. CHARGES MOVED TO NON-COVERED.
961	THIS REV CODE IS NOT PAYABLE WHEN BILLED W/ ALL INCLUSIVE REVENUE CODE 101 AND ALL INCLUSIVE ANCILLARY REVENUE CODE 240. CHARGES MOVED TO NON-COVERED.
962	PREGNANCY ALERT.
963	DRUG/GENDER ALERT.
964	CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES ARE NOT PAYABLE TO MEMBERS THIS AGE.
965	CLAIM DENIED. CHILDREN'S TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO MEMBERS OVER AGE 20.
966	CLAIM DENIED. ADULT TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO MEMBERS UNDER AGE 18.
967	CLAIM DENIED. REIMBURSEMENT FOR THIS REVENUE CODE IS LIMITED TO TWO UNITS OF SERVICE PER DAY.
968	CLAIM DENIED. REIMBURSEMENT FOR THIS REVENUE CODE IS LIMITED TO ONE UNIT OF SERVICE PER DAY.
969	THIS PROCEDURE CODE REQUIRES THE ENTRY OF A VALID QUADRANT CODE IN THE TOOTH NUMBER FIELD.
970	THIS PROCEDURE REQUIRES THE ENTRY OF A VALID ARCH CODE IN THE TOOTH NUMBER FIELD.
971	LITER FLOW PER MINUTE AND/OR NUMBER OF HOURS MISSING OR INVALID.
972	CLAIM DENIED. PROCEDURE CODES FOR MILEAGE, OXYGEN, AND SUPPLIES MUST MATCH THE BASE RATE CATEGORY.
973	PIN RETENTION THERAPY IS LIMITED TO ONE TOOTH PER DETAIL.
974	DUPLICATE TOOTH NUMBERS ARE NOT ALLOWED ON THE SAME DETAIL FOR GINGIVECTOMY PROCEDURE.
975	UNITS MUST EQUAL NUMBER OF TEETH PER DETAIL FOR PROCDURE GINGIVECTOMY PROCEDURE.
976	PIN RETENTION THERAPY IS LIMITED TO PERMANENT MOLARS ONLY.
977	TYPE OF BILL INVALID FOR PROVIDER TYPE.
978	CLAIM DENIED. ONLY ONE BASE RATE PROCEDURE CODE ALLOWED PER CLAIM.
979	CLAIM DENIED. EMERGENCY TRANSPORTATION CLAIMS WITH DATES OF SERVICE ON OR AFTER 7/1/95 MUST BE SUBMITTED ON PAPER.
980	COPAY FOR THIS SERVICE IS ADDITIVE. THE COPAY AMOUNT WAS CREDITED TO THE MEMBER'S ANNUAL OUT-OF-POCKET USED AMOUNT BUT WAS NOT DEDUCTED FROM YOUR CLAIM.
981	CLAIM DENIED. PAPER BILLING ONLY ALLOWED FOR MEMBERS IN CERTAIN COUNTIES, FOR CERTAIN PROCEDURE CODES, FOR DATES OF SERVICE AFTER 11/30/02. PLEASE VERIFY OUR
982	CLAIM/DETAIL DENIED. VACCINE PROCEDURE CODE MUST BE BILLED USING MODIFIER 26 FOR ADMINISTRATION TO INDICATE VACCINE OBTAINED FROM PRIVATE SOURCE.
984	MEDICARE EOMB DOES NOT INDICATE THAT COINSURANCE AND DEDUCTIBLE AMOUNTS ARE DUE.
985	DETAIL DENIED. THIS PROCEDURE LIMITED TO TWO UNITS OF SERVICE.
986	DETAIL DENIED. PROCEDURE CODE A0420 MUST ALSO BE BILLED WHEN AN EXTRA MILEAGE PROCEDURE CODE IS BILLED WITH A ROUND TRIP PROCEDURE CODE.
987	DETAIL DENIED. PROCEDURE CODES A0070 AND A0422 LIMITED TO 1 UNIT OF SERVICE IF BASE RATE INDICATES ONE WAY TRIP.
988	HEADER MEDICARE ALLOWED AMOUNT IS NOT EQUAL TO THE SUM OF THE DETAIL MEDICARE ALLOWED AMOUNTS.
989	CLAIM/DETAIL DENIED. RETURN MILEAGE NOT PAYABLE WHEN BILLING FOR ONE WAY TRIP.
990	DETAIL DENIED. SERVICES NOT PAYABLE BEYOND THE MONTH OF THE MEMBER'S THIRD BIRTHDAY.
991	KYCONV-DESCRIPTION NOT FOUND
992	DETAIL DENIED. PROCEDURE CODE INVALID FOR PROVIDER TYPE 13.
993	CLAIM/DETAIL DENIED. SERVICES NOT PAYABLE ON SAME DATE OF SERVICE AS AIR AMBULANCE.
994	CLAIM/DETAIL DENIED. MILEAGE PROCEDURE CODES NOT PAYABLE SAME DATE OF SERVICE AS ADDITIONAL PASSENGER PROCEDURE CODES.
996	NUMBER OF STUDENTS IN GROUP MISSING OR INVALID.
997	CLAIM PAID ZERO DUE TO INVALID PRESCRIBER LICENSE NUMBER. PLEASE RESUBMIT AN ADJUSTMENT WITH CORRECTED VALID PRESCRIBER LICENSE NUMBER.
998	CLAIM TEMPORARILY SUSPENDED UNTIL NEW FEE UPDATE IS IMPLEMENTED.
999	PENDING FOR REVIEW.
1000	INDIVIDUAL/BILLING PROVIDER(GROUP)/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE.
1001	INDIVIDUAL/BILLING PROVIDER (GROUP)/NPI NUMBER(S) NOT ENROLLED AT SERVICE LOCATION FOR PROGRAM BILLED (HEADER).
1002	COB - PAYER
1003	INDIVIDUAL/BILLING PROVIDER (GROUP)/NPI NUMBER(S) NOT ENROLLED AT SERVICE LOCATION FOR PROGRAM BILLED (HEADER).
1004	CLAIM SUBMITTED WITH INVALID OR NO ICD VERSION.
1005	CLAIM DENIED. CLAIM DOS CANNOT SPAN ICD10 EFFECTIVE DATE.
1006	FACILITY PROV NOT ELIG AT SERV LOC FOR PROG BILLED
1007	REVENUE CODES 681, 682, AND 683 684 CAN BE BILLED ONLY BY TRAUMA CENTERS/HOSPITALS DESIGNATED AS SUCH BY THE STATE OR LICENSING.
1008	REVENUE CODE BILLED DOES NOT MATCH THE DESIGNATED LEVEL OF TRAUMA FOR HOSPITALPROVIDER.
1009	REQUIRED DOCUMENTATION AND/OR INVOICE IS MISSING OR DOES NOT SUPPORT TRAUMA TEAM ACTIVATION/RESPONSE.
1010	RENDERING PROVIDER NOT A MEMBER OF BILLING GROUP.
1011	INTERNAL ERROR
1015	CLAIM DENIED. ONE OF THE PROVIDERS SUBMITTED ON YOUR CLAIM IS NOT ENROLLED WITH KY MEDICAID. PLEASE GO TO KY MPPA TO ENROLL THE PROVIDER, HTTPS://MEDICAIDSY
1016	NON-PARTICIPATING MANUFACTURER
1018	NO PRICING SEGMENT FOR LEVEL OF CARE
1037	FACILITY PROVIDER I.D. NOT ON FILE
1042	RENDERING PROVIDER IS NOT ELIGIBLE.
1043	REFERRING PROVIDER IS NOT ELIGIBLE.
1046	FACILITY PROVIDER IS NOT ELIGIBLE.
1047	BILLING PROVIDER IS NOT ELIGIBLE.
1049	BILLING PROVIDER IS SUSPENDED OR TERMINATED.
1052	TAXONOMY CODE INVALID FOR RENDERING PROVIDER
1053	TAXONOMY CODE INVALID FOR PERFORMING PROVIDER
1054	TAXONOMY CODE INVALID FOR BILLING PROVIDER
1055	DTL REFERRING PROV NOT ON FILE
1058	NO PAY TO PROVIDER RECORD FOR CROSSOVER CLAIM
1059	THIS SERVICE IS NOT A VALID ENCOUNTER UNDER THE SOONERCARE CHOICE PROGRAM UNLESS IT IS BILLED BY THE MEMBER'S PCP/CM.
1060	NO RENDERING PROVIDER FOR CROSSOVER CLAIM
1061	NO FACILITY PROVIDER FOR CROSSOVER CLAIM
1073	CLAIM/SERVICE DENIED. THE BILLING PROVIDER SUBMITTED A CROSSOVER CLAIM THAT WASNOT SUBMITTED FROM `COBA? (MEDICARE).
1106	THIS GLOBAL CPT-4 PROCEDURE CODE HAS BEEN ADDED TO MORE ACCURATELY REFLECT THE SERVICE PERFORMED. THE BILLED AMOUNT FOR THIS PROCEDURE IS THE SUM OF THE TOTA
1112	DETAIL DENIED. THE PROCEDURE BILLED HAS BEEN REBUNDLED TO A GLOBAL CPT-4 CODE THAT MORE ACCURATELY REFLECTS THE COMPREHENSIVE NATURE OF THE SERVICE THAT WAS
1117	CHRIS TEST

1118	THIS DRUG NOT COVERED BY MEDICARE PART D
1121	FOR QMB ONLY MEMBERS, THIS SERVICE IS NOT PAYABLE. FOR QDWI, QI1, QI2, AND SLMB MEMBERS, KENTUCKY MEDICAID PROGRAM IS ONLY RESPONSIBLE FOR BUY-IN PREMIUMS.
1123	THIS GLOBAL CPT-4 PROCEDURE CODE HAS BEEN ADDED TO MORE ACCURATELY REFLECT THE SERVICE PERFORMED. THE BILLED AMOUNT FOR THIS PROCEDURE IS THAT SUM OF THE TOT
1129	DETAIL DENIED. PROCEDURE BILLED WAS PERFORMED WITH A PRIMARY PROCEDURE. ACCORDING TO THE NATIONAL CORRECT CODING GUIDE THIS PROCEDURE IS CONSIDERED CONTENT OF
1606	MISSING OR INVALID PAYER DATE
1643	INVALID OTHER COVERAGE CODE
1652	MISSING OR INVALID OTHER PAYER COVERAGE TYPE
1750	REFERRING OR ORDERING PROVIDER NPI IS REQUIRED FOR THIS SERVICE.
1751	HEADER REFERRING PROVIDER1 NPI IS NOT ON FILE.
1752	HEADER REFERRING PROVIDER1 NPI IS NOT VALID FOR THE DATE OF SERVICE.
1753	HEADER REFERRING PROVIDER1 NPI DOES NOT HAVE A MATCHING ORP MEDICAID PROVIDER ID FOR THE DATE OF SERVICE.
1754	HEADER REFERRING PROVIDER2 NPI IS NOT ON FILE.
1755	HEADER REFERRING PROVIDER2 NPI IS NOT VALID FOR THE DATE OF SERVICE.
1756	HEADER REFERRING PROVIDER2 NPI DOES NOT HAVE A MATCHING ORP MEDICAID PROVIDER ID FOR THE DATE OF SERVICE.
1757	DETAIL REFERRING PROVIDER1 NPI IS NOT ON FILE.
1758	DETAIL REFERRING PROVIDER1 NPI IS NOT VALID FOR THE DATE OF SERVICE.
1759	DETAIL REFERRING PROVIDER1 NPI DOES NOT HAVE A MATCHING ORP MEDICAID PROVIDER ID FOR THE DATE OF SERVICE.
1760	DETAIL REFERRING PROVIDER2 NPI IS NOT ON FILE.
1761	DETAIL REFERRING PROVIDER2 NPI IS NOT VALID FOR THE DATE OF SERVICE.
1762	DETAIL REFERRING PROVIDER2 NPI DOES NOT HAVE A MATCHING ORP MEDICAID PROVIDER ID FOR THE DATE OF SERVICE.
1763	DETAIL ORDERING PROVIDER NPI IS NOT ON FILE.
1764	DETAIL ORDERING PROVIDER NPI IS NOT VALID FOR THE DATE OF SERVICE.
1765	DETAIL ORDERING PROVIDER NPI DOES NOT HAVE A MATCHING ORP MEDICAID PROVIDER IDFOR THE DATE OF SERVICE.
1766	REFERRING PROVIDER1 NPI IS NOT ON FILE OR NOT VALID FOR THE DATE OF SERVICE ONTHIS DENTAL CLAIM.
1767	CANNOT DETERMINE MEDICAID ID FROM THE NPI. REFERRING PROVIDER1 TAXONOMY IS REQUIRED FOR THIS DENTAL CLAIM. PLEASE RESUBMIT WITH TAXONOMY.
1768	REFERRING PROVIDER1 TAXONOMY ON THIS DENTAL CLAIM IS NOT ON FILE.
1769	REFERRING PROVIDER1 NPI/TAXONOMY COMBINATION NOT FOUND FOR THIS DENTAL CLAIM.
1770	REFERRING PROVIDER1 NPI/TAXONOMY COMBINATION NOT VALID FOR THE DATE OF SERVICEON THIS DENTAL CLAIM.
1771	REFERRING PROVIDER1 MEDICAID PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE ON THIS DENTAL CLAIM.
1772	THE REFERRING PROVIDER1 ON THIS DENTAL CLAIM IS NOT A VALID ORP MEDICAID PROVIDER TYPE OR IS NOT AN INDIVIDUAL PROVIDER.
1773	REFERRING PROVIDER2 NPI IS NOT ON FILE OR NOT VALID FOR THE DATE OF SERVICE ONTHIS DENTAL CLAIM.
1774	CANNOT DETERMINE MEDICAID ID FROM THE NPI. REFERRING PROVIDER2 TAXONOMY IS REQUIRED FOR THIS DENTAL CLAIM. PLEASE RESUBMIT WITH A TAXONOMY.
1775	REFERRING PROVIDER2 TAXONOMY ON THIS DENTAL CLAIM IS NOT ON FILE.
1776	REFERRING PROVIDER2 NPI/TAXONOMY COMBINATION NOT FOUND FOR THIS DENTAL CLAIM.
1777	REFERRING PROVIDER2 NPI/TAXONOMY COMBINATION NOT VALID FOR THE DATE OF SERVICEON THIS DENTAL CLAIM.
1778	REFERRING PROVIDER2 MEDICAID PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE ON THIS DENTAL CLAIM.
1779	THE REFERRING PROVIDER2 ON THIS DENTAL CLAIM IS NOT A VALID ORP MEDICAID PROVIDER TYPE OR IS NOT AN INDIVIDUAL PROVIDER.
1780	ATTENDING PROVIDER NPI IS REQUIRED.
1781	ATTENDING PROVIDER NPI IS NOT ON FILE OR NOT VALID FOR THE DATE OF SERVICE.
1782	ATTENDING PROVIDER TAXONOMY IS NOT ON FILE.
1783	CANNOT DETERMINE ATTENDING MEDICAID ID FROM THE NPI. ATTENDING PROVIDER TAXONOMY IS REQUIRED. PLEASE RESUBMIT WITH ATTENDING PROVIDER TAXONOMY.
1784	ATTENDING PROVIDER NPI/TAXONOMY COMBINATION NOT FOUND.
1785	ATTENDING PROVIDER NPI/TAXONOMY COMBINATION NOT ELIGIBLE FOR THE HEADER FROM DATE OF SERVICE.
1786	ATTENDING PROVIDER MEDICAID ID IS NOT ELIGIBLE FOR THE DATE OF SERVICE.
1787	ATTENDING PROVIDER IS NOT A VALID ORP MEDICAID PROVIDER TYPE.
1788	ATTENDING PROVIDER NPI DOES NOT HAVE A MATCHING ORP PROVIDER FOR THE DATE OF SERVICE.
1789	PRESCRIBING PROVIDER NPI IS NOT ON FILE OR DOES NOT HAVE A MATCHING ELIGIBLE PRESCRIBING PROVIDER FOR THE DATE OF SERVICE.
1800	BILLING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KYHEALTH CHOICES PROVIDER IDENTIFICATION NUMBER
1801	RENDERING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KY HEALTH CHOICES PROVIDER IDENTIFICATION NUMBER
1802	REFERRING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KY HEALTH CHOICES PROVIDER IDENTIFICATION NUMBER
1803	SERVICE FACILITY NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITHYOUR KY HEALTH CHOICES PROVIDER IDENTIFICATION NUMBER
1804	DETAIL RENDERING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITHYOUR KY HEALTH CHOICES PROVIDER IDENTIFICATION NUMBER
1805	DETAIL REFERRING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITHYOUR KY HEALTH CHOICES PROVIDER IDENTIFICATION NUMBER
1806	BILLING ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE
1807	RENDERING ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE
1808	REFERRING ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE
1809	SERVICE FACILITY ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE
1811	DETAIL RENDERING PROVIDER ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OFSERVICE
1812	DETAIL REFERRING ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE
1814	IF THE BILLING PROVIDER SUBMITS ANY OTHER SECONDARY NUMBER, POST THE EDIT.
1815	RENDERING PROVIDER SUBMITTED OTHER SECONDARY NUMBER ON CLAIM
1816	REFERRING PROVIDER SUBMITTED OTHER SECONDARY NUMBER ON CLAIM
1817	KENTUCKY FACILITY MEDICAID NUMBER SUBMITTED ON CLAIM. A VALID NPI MUST BE SUBMITTED AFTER MAY 22, 2008.
1818	OTHER PROVIDER 2 SUBMITTED OTHER SECONDARY NUMBER ON CLAIM
1819	DETAIL RENDERING PROVIDER SUBMITTED OTHER SECONDARY NUMBER ON CLAIM
1820	DETAIL REFERRING PROVIDER SUBMITTED OTHER SECONDARY NUMBER ON CLAIM
1821	DETAIL OTHER PROVIDER 2 SUBMITTED OTHER SECONDARY NUMBER ON CLAIM.
1822	RENDERING PROVIDER NPI NOT ON KY HEALTH CHOICES FILE
1823	REFERRING PROVIDER NPI NOT ON KY HEALTH CHOICES FILE
1824	SERVICE FACILITY PROVIDER NPI NOT ON KY HEALTH CHOICES FILE
1825	OTHER PROVIDER 2 NPI NOT ON KY HEALTH CHOICES FILE
1826	DETAIL RENDERING PROVIDER NPI NOT ON FILE
1827	DETAIL REFERRING PROVIDER NPI NOT ON FILE
1828	DETAIL OTHER PROVIDER 2 NPI NOT ON FILE
1829	RENDERING PROVIDER NPI NOT ON FILE
1830	REFERRING PROVIDER NPI NOT ON FILE
1831	SERVICE FACILITY PROVIDER NOT ON FILE
1832	OTHER PROVIDER 2 NPI NOT ON FILE
1833	DETAIL RENDERING PROVIDER NPI NOT ON FILE
1834	DETAIL REFERRING PROVIDER NPI NOT ON FILE
1835	DETAIL OTHER PROVIDER 2 PROVIDER NPI NOT ON FILE
1836	BILLING NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1837	RENDERING NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1838	REFERRING NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1839	FACILITY NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1840	OTHER PROVIDER 2 NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1841	RENDERING NPI ONLY SUBMITTED ON CLAIM AT DETAIL - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1842	REFERRING NPI ONLY SUBMITTED ON CLAIM AT DETAIL - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1843	OTHER PROVIDER 2 NPI ONLY SUBMITTED ON CLAIM AT DETAIL - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1844	KY HEALTH CHOICES BILLING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES OF SERVICE SUBMITTED
1845	KY HEALTH CHOICES RENDERING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIMS DATES OF SERVICE SUBMITTED
1846	KY HEALTH CHOICES REFERRING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIMS DATES OF SERVICE SUBMITTED
1847	KY HEALTH CHOICES SERVICE FACILITY MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATESOF SERVICE SUBMITTED
1848	KY HEALTH CHOICES OTHER PROVIDER 2 MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATESOF SERVICE SUBMITTED
1849	KY HEALTH CHOICES DETAIL RENDERING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATESOF SERVICE SUBMITTED
1850	KY HEALTH CHOICES DETAIL REFERRING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATESOF SERVICE SUBMITTED

1851	KY HEALTH CHOICES DETAIL OTHER PROVIDER 2 MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES OF SERVICE SUBMITTED
1852	SUBMITTED BILLING TAXONOMY CODE AT HEADER IS NOT A VALID CODE - CHECK FOR VALIDTAXONOMY CODES AT WWW.WPC-EDI.COM
1853	SUBMITTED RENDERING TAXONOMY CODE AT HEADER IS NOT A VALID CODE - CHECK FOR VALID TAXONOMY CODE AT WWW.WPC-EDI.COM
1854	WARNING - SUBMITTED REFERRING TAXONOMY CODE AT HEADER IS NOT VALID CODE - CHECKFOR VALID TAXONOMY CODES AT WWW.WPC-EDI.COM
1856	SUBMITTED DETAIL RENDERING TAXONOMY CODE IS NOT A VALID CODE - CHECK FOR VALID TAXONOMY CODE AT WWW.WPC-EDI.COM
1857	BILLING TAXONOMY CODE FOR PROVIDER NOT VALID FOR DATE OF SERVICE
1858	RENDERING TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE
1859	REFERRING TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE
1861	DETAIL RENDERING TAXONOMY CODE FOR PROVIDER NOT VALID FOR DATE OF SERVICE
1862	BILLING PROVIDER TAXONOMY CODE NOT VALID FOR PROVIDER FOR DATE OF SERVICE.
1863	HEADER RENDERING PROVIDER TAXONOMY CODE NOT VALID FOR PROVIDER FOR DATE OF SERVICE.
1864	REFERRING PROVIDER TAXONOMY CODE MIS/MATCH FOR CLAIM DATE OF SERVICE
1866	DETAIL RENDERING PROVIDER TAXONOMY CODE NOT VALID FOR PROVIDER FOR DATE OF SERVICE.
1870	BILLING PROVIDER SUBMITTED NPI AND LEGACY NUMBER. LEGACY NUMBER NOT PROCESSED
1871	REFERRING PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSED
1872	RENDERING PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSED
1873	SERVICE FACILITY PROV SUBMITTED NPI AND LEGACY NUM- LEGACY NUM NOT PROCESSED
1874	OTHER PROVIDER 2 PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSED
1875	RENDERING PROVIDER SUBMITTED NPI AND LEGACY NUMBER. LEGACY NUMBER NOT PROCESSED
1876	REFERRING PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSED
1877	OTHER PROVIDER 2 PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSED
1878	PRESCRIBER'S NPI IS INVALID
1879	PRESCRIBER'S NPI IS MISSING
1880	PRESCRIBER'S NPI IS NOT ON FILE
1881	BILLING PROVIDER TAXONOMY IS MISSING.
1882	RENDERING PROVIDER TAXONOMY IS MISSING.
1900	NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KY HEALTHCHOICES PROVIDER IDENTIFICATION NUMBER
1901	NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KY HEALTHCHOICES PROVIDER IDENTIFICATION NUMBER
1902	KY HEALTH CHOICES MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES OF SERVICE SUBMITTED
1903	KY HEALTH CHOICES MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES OF SERVICE SUBMITTED
1904	WARNING - NPI AND KY HEALTH CHOICES MEDICAID NUMBER SUBMITTED ON CLAIM - NPI ISNOT ELIGIBLE FOR THE CLAIM SUBMITTED DATES OF SERVICE
1905	WARNING - NPI AND KY HEALTH CHOICES MEDICAID NUMBER SUBMITTED ON CLAIM - NPI ISNOT ELIGIBLE FOR THE CLAIM SUBMITTED DATES OF SERVICE
1906	WARNING - NPI NOT REGISTERED WITH KY HEALTH CHOICES - NPI SUBMITTED ON CLAIM ATHEADER NOT ON FILE - PLEASE VERIFY YOUR NPI NUMBER WITH KY HEALTH CHOICES
1907	WARNING - NPI NOT REGISTERED WITH KY HEALTH CHOICES - NPI SUBMITTED ON CLAIM ATDETAIL NOT ON FILE - PLEASE VERIFY YOUR NPI NUMBER WITH KY HEALTH CHOICES
1908	BILLING NPI ONLY SUBMITTED ON CLAIM. NPI IS NOT ON FILE
1909	TAXONOMY IS NOT VALID FOR FACILITY PROVIDER
1910	NPI ONLY SUBMITTED ON CLAIM AT HEADER ? NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1911	NPI ONLY SUBMITTED ON CLAIM AT DETAIL ? NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM
1912	WARNING - SUBMITTED TAXONOMY CODE AT HEADER IS NOT A VALID CODE - CHECK FOR VALID TAXONOMY CODES AT WWW.WPC-EDI.COM
1913	WARNING - SUBMITTED TAXONOMY CODE AT DETAIL IS NOT A VALID CODE - CHECK FOR VALID TAXONOMY CODES AT WWW.WPC-EDI.COM
1914	PROVIDER NPI NOT ON KY HEALTH CHOICES FILE
1915	PROVIDER NPI NOT ON FILE
1916	PROVIDER NPI NOT ON FILE
1917	PROVIDER NPI NOT ON FILE - DETAIL
1918	WARNING - BILLING PROVIDER 5 DIGIT ZIP CODE DOES NOT MATCH WHAT IS REGISTERED WITH KY HEALTH CHOICES - PLEASE VERIFY YOUR 5 DIGIT ZIP CODE WITH KY HEALTH CHOI
1919	WARNING - BILLING PROVIDER 5 + 4 DIGIT ZIP CODE DOES NOT MATCH WHAT IS REGISTERED WITH KY HEALTH CHOICES - PLEASE VERIFY YOUR 5 + 4 DIGIT ZIP CODE WITH KY HEA
1920	WARNING - KENTUCKY MEDICAID NUMBER SUBMITTED ON CLAIM. A VALID NPI ONLY MUST BE SUBMITTED AFTER MAY 22, 2008
1921	WARNING - KENTUCKY MEDICAID NUMBER SUBMITTED ON CLAIM AT DETAIL - NPI ONLY MUSTBE SUBMITTED AFTER MAY 22, 2008
1922	MULTIPLE KY MEDICAID MATCHES FOUND FOR NPI SUBMITTED - SERVICE FACILITY 5 DIGITZIP CODE SUBMITTED ON CLAIM DOES NOT MATCH PROVIDER FILE 5 DIGIT ZIP CODE
1923	MULTIPLE KY MEDICAID MATCHES FOUND FOR NPI SUBMITTED - SERVICE FACILITY 5 + 4 DIGIT ZIP CODE SUBMITTED ON CLAIM DOES NOT MATCH PROVIDER FILE 5 + 4 DIGIT ZIP
1924	TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE
1925	TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE
1926	PROVIDER TAXONOMY CODE MIS/MATCH FOR CLAIM DATE OF SERVICE
1927	PROVIDER TAXONOMY CODE MIS/MATCH FOR CLAIM DATE OF SERVICE
1936	INVALID BILLING PROVIDER OVERRIDE SPECIFIED
1937	INVALID PERFORMING PROVIDER OVERRIDE SPECIFIED
1938	INVALID REFERRING PROVIDER OVERRIDE SPECIFIED
1939	INVALID FACILITY PROVIDER OVERRIDE SPECIFIED
1940	INVALID RENDERING PROVIDER OVERRIDE SPECIFIED
1941	INVALID OTHER PROVIDER 2 OVERRIDE SPECIFIED
1942	INVALID DTL OTHER PROVIDER 2 OVERRIDE SPECIFIED
1943	INVALID DTL PERFORMING PROVIDER OVERRIDE SPECIFIED
1944	INVALID DTL REFERRING PROVIDER OVERRIDE SPECIFIED
1945	MULTIPLE SERVICE LOCATIONS FOR BILLING PROVIDER
1946	MULTIPLE SERVICE LOCATIONS FOR PERFORMING PROVIDER
1947	MULTIPLE SERVICE LOCATIONS FOR REFERRING PROVIDER
1948	MULTIPLE SERVICE LOCATIONS FOR FACILITY PROVIDER
1949	MULTIPLE SERVICE LOCATIONS FOR RENDERING PROVIDER
1950	PROCEDURE INCLUDED IN BUNDLED RATE
1951	HCPC IS REQUIRED
1952	MULTIPLE SERVICE LOCS FOR DTL PERFORMING PROVIDER
1953	MULTIPLE SERVICE LOCS FOR DTL REFERRING PROVIDER
1955	CLAIM/SERVICE DENIED. THE BILLING PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE BILLING PROVIDER.
1956	CLAIM/SERVICE DENIED. THE REFERRING PROVIDER NPI SUBMITTED ON THE CLAIM CANNOTBE USED TO UNIQUELY IDENTIFY THE REFERRING PROVIDER.
1957	CLAIM/SERVICE DENIED. THE FACILITY PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE FACILITY PROVIDER.
1958	CLAIM/SERVICE DENIED. THE OTHER PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BEUSED TO UNIQUELY IDENTIFY THE OTHER PROVIDER.
1959	CLAIM/SERVICE DENIED. THE PERFORMING PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE PERFORMING PROVIDER.
1960	CLAIM/SERVICE DENIED. THE DETAIL REFERRING PROVIDER NPI SUBMITTED ON THE CLAIMCANNOT BE USED TO UNIQUELY IDENTIFY THE DETAIL REFERRING PROVIDER.
1961	CLAIM/SERVICE DENIED. THE DETAIL OTHER PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE DETAIL OTHER PROVIDER.
1962	CLAIM/SERVICE DENIED. THE DETAIL PERFORMING PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE DETAIL PERFORMING PROVIDER.
1963	CLAIM/SERVICE DENIED. THE KENPAC PROVIDER NPI SUBMITTED ON THE CLAIM DOES NOT MATCH THE PRIMARY CARE PHYSICIAN FOR THE MEMBER ON THE CLAIM.
1964	THE LOCK IN PROVIDER NPI SUBMITTED ON THE CLAIM DOES NOT MATCH THE PRIMARY CAREPHYSICIAN FOR THE MEMBER ON THE CLAIM.
1965	CLAIM DENIED. PLEASE RESUBMIT CLAIM WITH THE NPI THAT CORRESPONDS TO YOUR KY MEDICAID PROV NUMBER. IF YOU HAVE REGISTERED ONE NPI FOR MULTIPLE KY PROV TYPES
1966	THE PROVIDER NPI AND TAXONOMY SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELYIDENTIFY THE PROVIDER
1967	THE PROVIDER NPI AND SERVICE FACILITY 5 DIGIT ZIP CODE SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE PROVIDER
1968	THE PROVIDER NPI AND SERVICE FACILITY 5 + 4 DIGIT ZIP CODE SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE PROVIDER
1969	THE PROVIDER NPI AND BILLING PROVIDER 5 DIGIT ZIP CODE SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE PROVIDER
1970	THE PROVIDER NPI AND BILLING PROVIDER 5 + 4 DIGIT ZIP CODE SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE PROVIDER
1971	THE KY MEDICAID NUMBER SUBMITTED ON THE CLAIM DOES NOT MATCH THE CROSS-WALKED KY MEDICAID NUMBER FROM THE NPI
1972	THE KY MEDICAID NUMBER SUBMITTED ON THE CLAIM DOES NOT MATCH THE CROSS-WALKED KY MEDICAID NUMBER FROM THE NPI
1995	MMIS FACILITY PROVIDER ID NOT ENROLLED
1996	THE RENDERING PROVIDER IS NOT ENROLLED IN THE MEDICAID PROGRAM.
1997	THIS CLAIM WAS BILLED WITH A RENDERING PROVIDER NUMBER FROM THE PREVIOUS MEDICAID SYSTEM. PLEASE BILL FUTURE CLAIMS WITH THE PROVIDER NUMBER ASSIGNED DURING
1999	BILLING PROVIDER ID SUMITTED UNDER OLD FORMAT
2000	ERROR DISPOSITION SETUP IS INVALID
2001	MEMBER ID NUMBER NOT ON FILE.

2002	MEMBER NOT ELIGIBLE FOR HEADER DATE OF SERVICE.
2003	MEMBER INELIGIBLE ON DETAIL DATE OF SERVICE.
2004	PROCEDURE INCLUDED IN COMBINED PROCEDURE
2005	PRESCRIPTION LIMIT EXCEEDED FOR THIS MONTH
2006	RX-EXCEEDS DAYS SUPPLY LIMIT/REQUIRES PA
2007	PA NOT AUTHORIZED FOR DRUG THERCLASS 46 & 47
2008	EXCEEDS EMERGENCY ROOM VISITS FOR THIS DATE
2009	MEMBER INELIGIBLE ON DATE OF SERVICE.
2010	MULTIPLE ACTIVE PREVIOUS ID'S FOUND FOR MEMBER.
2011	MATERNITY CLINIC/PHY CONFLICT FOR PRENATAL SERVICE
2012	MAXIMUM CRITICAL CARE VISITS EXCEEDED
2013	EXCEEDS 9 MO LIMIT FOR THIS LEVEL PRENATAL CARE
2014	EXCEEDS MONTHLY CLINIC VISIT LIMITS
2015	SCHOOL BASED YEARLY LIMIT EXCEEDED
2016	LIMIT OF HH VISITS HAS BEEN EXCEEDED FOR 1 YEAR
2017	LIMIT FOR CHMC SERVICE HAS BEEN EXHAUSTED
2018	DIABETIC SUPPLIES LIMITS EXCEEDED
2019	12 MONTH LIMIT FOR THIS DENTAL SERVICE IS EXCEEDED
2020	YEARLY LIMIT FOR EYE GLASSES EXCEEDED
2021	12 MONTH LIMIT FOR THIS DENTAL SERVICE IS EXCEEDED
2022	A CONFLICTING SERVICE HAS BEEN PAID FOR THIS DATE
2023	DEALER LIMITS EXCEEDED
2024	OTHER FED QUAL HEALTH CENTER SERV PAID THIS DATE
2025	EXCEEDS EARLY INTERVENTION SERVICES LIMITS
2026	EXCEEDS EPSDT CLINIC LIMITS
2027	EXCEEDS OB ULTRASOUND LIMIT FOR 9 MONTHS
2028	EXCEEDS NUTRITIONAL SERVICE FOR YEAR
2029	EXCEEDS HOME COM BASED WAIVERED SERVICE LIMITS
2030	SAME SERV WITH 91/92 HCPC HAS BEEN PAID THIS DATE
2031	EXCEPTION CODE 031
2032	MAXIMUM RENTAL PAYMENT
2033	HIGHER CEREBRAL FUNCTION PREVIOUSLY PAID IN 12 MTS
2034	EXCEEDS YEARLY EARLY INTERVENTION CASE MAN LIMITS
2035	THE 2 PHY VISIT PER MONTH LIMIT HAS BEEN EXCEEDED
2036	ADD'L HOURS OF TESTING REQUIRE PRIOR AUTHORIZATION
2037	MAXIMUM PAYMENT MADE
2038	EXCEEDS OXYGEN LIMITS-ONE PER MONTH
2039	TARGETED ULTRASOUND/AMNIOCENTISIS REVIEW
2040	THE MAMMOGRAM LIMIT HAS BEEN EXCEEDED
2041	EXCEPTION CODE 041
2042	EXCEEDS ONCE PER MONTH LIMIT
2043	ONE NEWBORN EXAM HAS BEEN PAID FOR THIS CHILD
2044	PREVIOUSLY PAID-VISIT OR W3011-THIS DATE OF SERV.
2045	EXCEPTION CODE 045
2046	EXCEPTION CODE 046
2047	EXCEED PART A SKILLED NURSING FACILITY COINS LIMIT
2048	CONFLICTING DENTAL SERVICE SAME DAY
2049	EXCEEDS PSYCHOLOGICAL LIMIT PER MONTH
2050	EXCEPTION CODE 050
2051	EXCEEDS 2 VISIT LIMIT
2052	NO LTC STAFFING SUBMITTED FOR SERVICE MONTH
2053	LTC EMC CLAIM INVALID WHEN STAFFING IS SENT PAPER
2054	PCS INELIGIBLE FOR CATEGORY OF SERVICE
2055	2 RURAL HEALTH VISITS PER MONTH HAS BEEN EXCEEDED
2056	TRIGGER POINT INJECTION LIMIT HAS BEEN EXCEEDED
2057	OUTPATIENT MENTAL HEALTH LIMITS EXCEEDED
2058	YEARLY ASSISTATIVE TECHNOLOGY LIMIT EXCEEDED
2059	EXCEPTION CODE 059
206	PRESC PRACT LICENSE NUMBER NOT IN VALID FORMAT
2060	EXCEPTION CODE 060
2061	EXCEPTION CODE 061
2062	EXCEPTION CODE 062
2063	EXCEPTION CODE 063
2064	EXCEPTION CODE 064
2065	EXCEPTION CODE 065
2066	EXCEPTION CODE 066
2067	EXCEPTION CODE 067
2068	EXCEPTION CODE 068
2069	EXCEPTION CODE 069
2070	2 NURSING HOME VISITS PREVIOUSLY PAID THIS MONTH
2071	THIS SERV HAS BEEN PREVIOUSLY PAID FOR THIS MEMBER
2072	PREVIOUSLY PAID VISUAL EXAM IN 12 MONTHS
2073	EXCEPTION CODE 073
2074	PREVIOUSLY PAID 3 PAP SMEARS IN 12 MONTHS
2075	MEMBER HAS OVERLAPPING PATIENT LIABILITY SEGMENTS. PLEASE CONTACT EDS PROVIDERRELATIONS.
2076	EXCEEDS YEARLY FAMILY PLANNING EXAM LIMIT
2077	EXCEPTION CODE 077
2078	MEMBER HAS MULTIPLE BENEFIT PLANS FOR THE DATE OF SERVICE RANGE.
2079	EXCEPTION CODE 079
2080	PREVIOUSLY PAID AUDITORY EXAM IN 12 MONTHS
2081	CHILDRENS DAYS EXCEEDED
2082	CHILDRENS DAYS EXHAUSTED
2083	CHILDRENS VISITS EXCEEDED
2084	CHILDRENS VISITS EXHAUSTED
2085	CHILDREN DAYS EXCEEDED FOR FISCAL YEAR PA REQUIRED
2086	CHILDREN DAYS EXCEEDED FOR FISCAL YEAR PA REQUIRED
2087	TB DRUG
2088	EXCEPTION CODE 088
2089	EXCEPTION CODE 089
2090	PCS - 1500
2091	MEMBER HAS MULTIPLE INSTITUTIONAL STATUS CODE. PLEASE CONTACT EDS.
2092	ALIEN-NO REQUEST FOR AUTHORIZATION RECEIVED
2095	REVIEW INVALID CARRIER DENIED BATCH
2096	DDSD HAS DENIAL/SUSPEND EDIT
2098	HCBW WAIVER HAS DENY/SUSPEND EDIT
2099	MANUALLY SUSPEND FOR HCA

2101	ADP WAIVER HAS DENY/SUSP EDIT
2103	PROCEDURE NOT COVERED WITH THIS PLACE OF SERVICE
2104	INVALID PROVIDER SPECIALTY FOR PROCEDURE
2105	INVALID DIAGNOSIS FOR PROCEDURE
2106	MEMBER NAME IS MISSING
2110	PCS CLAIM - MEMBER NOT PCS ELIGIBLE
2112	MISSING TOTAL CHARGE FOR NURSING HOME CLAIMS
2114	OUTPT HSP PRIOR TO 12/01/99-SUSPEND FOR REVIEW
2115	VISIT WITHIN NORMAL SURGERY FOLLOW-UP PERIOD
2116	EXCEPTION CODE 116
2117	2 YEAR RESUBMISSION DEADLINE EXCEEDED
2118	DISCHARGE DATE IS LESS THAN ADMIT DATE
2119	DISCHARGE DATE IS LESS THAN LAST DATE OF SERVICE
2120	VISIT PAID IN NORMAL SURGERY FOLLOW-UP PERIOD
2121	CLAIM WAS FILED WITHOUT SERVICING PROVIDER
2122	INVALID/MISSING PROVIDER CHECK-DIGIT NUMBER
2123	INVALID/MISSING PAY-TO PROVIDER CHECK-DIGIT NUMBER
2124	MISSING FIRST DATE OF SERVICE ON CLAIM
2125	ONE YEAR TIMELY FILING DEADLINE EXCEEDED-FED REG
2126	FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV
2127	DATE RECEIVED FOR PROCESSING-PRIOR TO DATE OF SERV
2128	DATE OF ACCIDENT IS GREATER THAN LAST DATE OF SERV
2129	MISSING MEMBER ID NUMBER ON CLAIM
2130	EXCEPTION CODE 130
2132	MISSING TOTAL CLAIM CHARGE
2133	INVALID TOTAL CLAIM CHARGE
2134	INVALID NET CLAIM CHARGE
2136	MISSING/INVALID REVENUE CODE
2138	MISSING/INVALID TYPE OF BILL
2140	HCPC CODE IS INVALID FOR REVENUE CODE
2141	TOTAL DAYS LESS THAN COVERED DAYS
2142	1 YR TIMELY FILE HAS BEEN OVERRIDDEN-TF ATTACHED
2143	REFILLS EXHAUSTED
2144	INVALID REFILL INDICATOR VALUE
2146	HCPC/REVENUE CODE MISSING
2147	DIAGNOSIS NOT COVERED FOR THIS CLAIM TYPE FOR MEMBER'S BENEFIT PLAN
2148	PROCEDURE NOT PAYABLE THIS MEMBER
2149	PROC REQUIRES REVIEW CATEGORICALLY NEEDY MEMBER
2150	UNITS OF SERVICE ARE LESS THAN PROC ALLOWED UNITS
2151	MISSING PRESCRIBING PROVIDER NUMBER
2152	MISSING DRUG CODE
2153	INVALID DRUG CODE
2154	MISSING PRESCRIPTION NUMBER
2155	MISSING DRUG QUANTITY
2156	MISSING DAYS SUPPLY
2160	MISSING DIAGNOSIS INDICATOR
2163	MISSING DIAGNOSIS CODE
2166	MEMBER ELIGIBILITY PENDING DHS APPROVAL
2167	INVALID PATIENT STATUS
2168	INVALID SOURCE OF ADMISSION
2170	INVALID PLACE OF SERVICE
2172	CLAIM REQUIRES HCPC OR CPT-4 CODE
2173	ADMIT DATE GREATER THAN FIRST DATE OF SERVICE
2174	UNITS CANNOT BE LESS THAN DAYS
2175	SURGICAL PROCEDURE MISSING
2176	MEMBER NOT ON FILE PAY FROM STATE FUNDS
2178	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2179	MISSING TOOTH SURFACE
2180	INVALID TOOTH NUMBER
2181	INVALID TOOTH SURFACE
2182	MISSING TOOTH NUMBER
2183	MISSING UNITS OF SERVICE
2184	MISSING CHARGE
2185	LTC MISSING ADMISSION DATE
2186	INVALID ADMISSION HOUR
2187	PROCEDURE NOT PAYABLE THIS MEMBER
2189	PROCEDURE REQUIRES MEDICAL REVIEW
2190	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2191	ITEM DAYS NOT EQUAL TO COVERED DAYS ON CLAIM
2192	TOTAL DAYS ON CLAIM CONFLICT WITH DATES SHOWN
2193	MISSING COVERED DAYS
2194	AGE IS NOT COVERED INPATIENT PSYCHIATRIC SERVICES
2196	MISSING ADMISSION DATE
2197	INVALID INPATIENT REVENUE CODE
2198	MISSING ATTENDING SURGEON PRESCRIBER NUMBER
2199	DATE OF SURGERY IS MISSING
2200	INVALID TYPE OF ADMISSION
2201	PROCEDURE CODE IS NOT IN THE SCOPE OF PROGRAM
2202	SUB TYPE REQUIRED FOR THIS DIAGNOSIS CODE
2203	CLAIMANT SIGNATURE MISSING
2204	PROVIDER SIGNATURE IS MISSING
2205	PATIENT NOT CERTIFIED
2206	PRESCRIBING PROVIDER NUMBER NOT IN VALID FORMAT
2207	INVALID LEVEL OF CARE
2208	INVALID PICKUP LOCATION
2209	INVALID DESTINATION
2210	FACILITY PROVIDER SERVICE LOCATION IS MISSING
2213	PREGNANCY INDICATOR INVALID
2214	DATE PRESCRIBED IS INVALID
2215	DATE DISPENSED IS MISSING
2216	DATE DISPENSED IS INVALID
2222	MISSING OCCURRENCE DATE
2223	SERVICE DATES ARE NOT IN SAME MONTH
2224	INVALID OCCURRENCE DATE
2226	INVALID CONDITION CODE
2227	EXCEPTION CODE 227

2228	MISSING MEDICARE PAID DATE
2230	NO CROSSOVER COINSURANCE OR DEDUCTIBLE DUE
2231	ESTIMATED DAYS SUPPLY INVALID
2233	INSURANCE DENIAL REQUIRED
2234	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2235	SURGERY DATE CANNOT BE PRIOR TO ADMIT DATE
2236	SURGERY DATE CANNOT BE OUTSIDE DATE OF SERVICE
2237	FACILITY PROVIDER NOT IN VALID FORMAT
2238	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN
2239	INVALID OCCURRENCE CODE
2240	THE DETAIL LINE "TO" DATE OF SERVICE IS MISSING.
2242	MISSING OCCURRENCE CODE
2244	INVALID PAY-TO PROVIDER NUMBER
2247	MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED
2249	CLAIM HAS NO DETAILS
2250	MEMBER IS NOT ON ELIGIBILITY FILE
2252	MEMBER IS NOT ELIGIBLE ALL DATES OF SERVICES
2253	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN
2254	MEMBER NOT IN MANAGED CARE
2258	MEMBER IS NOT ON ELIGIBILITY FILE
2259	DATE BILLED IS INVALID
2260	SLIMB ONLY/NO MEDICAL ELIGIBILITY
2262	PROCEDURES NOT PAYABLE TB
2263	PROCEDURE REQUIRES REVIEW FOR TB MEMBER
2265	CLAIM HAS THIRD-PARTY PAYMENT
2266	REFERRING PHYSICIAN NUMBER IS MISSING
2270	INPATIENT TB NOT COVERED
2271	MEMBER IS NOT ELIGIBLE ON SERVICE DATE
2272	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN
2273	SUSPENDED FOR MEMBER REVIEW
2274	CLAIM INDICATES MEMBER EXPIRED
2276	NEWBORN-HCA REVIEW
2277	BILLING PROVIDER IS NOT LISTED AS MEMBER'S LTC PROVIDER.
2278	DISCHARGE DTE UNEQ TO LTC ELIG
2281	ABORTION NOT COVERED
2282	PHYSICIAN AUDITOR REVIEW-MODIFIER 24
2285	MEMBER NOT ELIGIBLE FOR DATES OF SERVICE
2287	PROCEDURE NOT PAYABLE VR
2289	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2290	PROCEDURE IS NOT IN THE SCOPE OF THE PROGRAM
2291	PROCEDURE REQUIRES MEDICAL REVIEW
2292	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2294	PROC REQUIRES REVIEW - HCBW
2295	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2296	PROVIDER INELIGIBLE FOR PROCEDURES
2297	PAY TO PROVIDER NOT ELIG FOR PAY-THIS DATE OF SERV
2298	PROVIDER NUMBER IS A GROUP NUMBER
2300	NO PROVIDER MASTER RECORD
2302	PRESCRIBING PROVIDER NOT ON FILE
2303	PROVIDER IS SUSPENDED OR TERMINATED FOR PROGRAM BILLED.
2304	PROVIDER INELIGIBLE ON SERVICE DATE
2305	REVIEW CLAIMS FOR THIS PROVIDER
2306	PAY TO PROVIDER IS SUSPENDED
2307	BILLING OUT OF CLIA CERTIFICATE TYPE
2308	NO PAY-TO PROVIDER RECORD
2309	REVIEW CLAIM FOR PAY-TO- PROVIDER
2310	ANESTHESIA MODIFIER IS INVALID OR MISSING
2311	SERVICING PROVIDER IS NOT A MEMBER OF PAY TO GROUP
2312	PAY-TO PROVIDER NOT ENROLLED
2313	DIAGNOSIS CODE MISSING/NOT ON FILE
2314	SURGICAL PROCEDURE CODE NOT FOUND
2315	ICD 9 AND ICD 10 QUALIFIERS NOT ALLOWED ON THE SAME CLAIM.
2316	ATTACHMENT CONTROL NUMBER MISSING
2317	INVALID/MISSING MODIFIER FOR THIS PROCEDURE
2318	PROCEDURE REQUIRES MANUAL PRICING
2319	DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED
2321	PROCEDURE CODE IS NO LONGER VALID
2322	DATE OF SERVICE BEFORE PROCEDURE IS PAYABLE
2323	INVALID MEMBER AGE FOR THIS DIAGNOSIS
2324	INVALID MEMBER SEX FOR THIS DIAGNOSIS
2326	INVALID TOOTH NUMBER FOR THIS PROCEDURE
2327	PROCEDURE REQUIRES ADDITIONAL DOCUMENTATION
2328	PROCEDURE NOT IN SCOPE OF PROGRAM FOR THIS AGE
2329	INVALID MEMBER SEX FOR THIS PROCEDURE
2331	THIS DRUG NOT COVERED FOR THE MEMBER
2332	INVALID PROVIDER TYPE FOR THIS PROCEDURE
2335	LTC MEMBER - NONCOMP DRUG
2336	REFILLS ARE NOT ALLOWED FOR NARCOTIC DRUGS
2337	THIS DRUG REQUIRES PRIOR AUTHORIZATION
2338	LTC DRUG ONLY
2341	THIS DIAGNOSIS REQUIRES MEDICAL REVIEW
2342	THIS DIAGNOSIS REQUIRES MEDICAL REVIEW
2345	ATTENDING PROVIDER NOT FOUND
2346	REFERRING PROVIDER NOT FOUND
2347	THIS DIAGNOSIS REQUIRES MEDICAL REVIEW
2348	THIS DIAGNOSIS REQUIRES MEDICAL REVIEW
2349	MEMBER REQUIRES A PROGRAM CODE
235	PROCEDURE CODE NOT IN VALID FORMAT
2350	THE NUMBER OF DETAILS IS NOT EQUAL TO THE SUBMITTED DETAIL COUNT.
2351	SUBMITTED TO ALLOWED EXCEEDS PERCENT
2352	ALLOWED TO SUBMITTED EXCEEDS PERCENT
2354	THIS LAB NOT CERTIFIED TO PROVIDE THIS SERVICE
2356	NDC IS DEACTIVED AND NOT PAYABLE ON DATE FILLED
2357	THIS DRUG REQUIRES PRIOR AUTHORIZATION
2358	INACTIVE DRUG
2359	THIS DRUG REQUIRES PRIOR AUTHORIZATION

2360	THIS NATIONAL DRUG CODE IS NOT ON FILE
2361	PROCEDURE CODE IS MISSING/NOT ON FILE
2362	MEDICARE DEDUCTIBLE GREATER THAN MAXIMUM
2366	THIS DIAGNOSIS REQUIRES REVIEW
2369	MEDICARE COINSURANCE GREATER THAN MEDICARE PAID
2371	THIS DIAGNOSIS REQUIRES ADDITIONAL DOCUMENTATION
2372	ITEM NOT PAYABLE IN LONG TERM CARE FACILITY
2374	MISSING PRESCRIBER PROVIDER ON DEALER CLAIM
2375	SERVICE NOT ON EXPLANTION OF MEDICARE PAYMENTS
2377	MEMBER IS INELIGIBLE FOR THIS DRUG
2379	PROCEDURE CODE MODIFIER REQUIRES MANUAL REVIEW
2383	MULTIPLE SURGERY REQUIRES REVIEW
2385	REVENUE CODE NOT ON FILE
2388	IMPROPER MODIFIER FOR CRNA
2389	THIS MODIFIER IS ALLOWED FOR CRNA ONLY
2390	MULTIPLE EXTRACTION REQUIRES APPROPRIATE PROC CODE
2391	INVALID USE OF E DIAGNOSIS CODE
2394	VERIFY PCS TPL
2396	LOC ON CLAIM CONFLICTS WITH LOC ON FILE
2397	INVALID LTC TERMINATION CODE
2399	REFERRING PROVIDER I.D. # IS NOT IN A VALID FORMAT
2400	INVALID LOC DAYS
2401	INVALID LEAVE DAYS
2402	INVALID TYPE OF LEAVE
2406	LTC LEAVE DATES CONFLICT
2407	THERAPEUTIC DAYS GT THAN 14
2410	PA IS REQUIRED
2411	THERAPEUTIC DAYS USED EXCEEDS AUTHORIZATION
2412	DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL.
2413	LTC BLOCK 13:TOTAL DAYS DO NOT EQUAL FROM/TO DAYS
2414	WAIVER SERVICES LONG TERM CARE CONFLICT
2416	AMB SERVICES ORIGIN TO DESTINATION NOT IN SCOPE
2417	REVIEW AMBULANCE NON ROUTINE DESTINATION
2420	THIS DRUG NOT PAYABLE FOR MEMBER AGE
2421	THIS DRUG NOT PAYABLE FOR MEMBER SEX
2425	THIS PROCEDURE MUST BE BILLED SEPARATELY EACH DATE
2430	LTC INVALID MEMBER ID NUMBER
2431	LTC NO PROV MASTER RECORD
2433	LTC MISSING PROVIDER NUMBER
2434	LTC INVALID PROV NUM CK-DIGIT
2435	LTC FIRST DATE OF SERVICE MISSING
2436	LTC FILING DEADLINE EXCEEDED
2437	LTC FIRST DATE GREATER LAST DATE
2438	LTC RECHECK SERVICE DATE
2439	LTC MISS MEMBER ID NUMBER
2443	LTC MEMBER NOT ON ELIG FILE
2444	LTC MEMBER INELIGIBLE ON SERVICE DATES
2445	LTC MEMBER NOT ELIGIBLE ON SERVICE DATES
2446	LTC MEMBER SUSPEND FOR REVIEW
2447	LTC PROV IS SUSPENDED
2448	LTC PROVIDER IS INELIGIBLE ON SERVICE DATES
2449	LTC REVIEW CLAIM FOR PROV
2450	INVALID QUADRANT
2451	LTC INV PROVIDER NUMBER
2452	RENDERING PROVIDER SERVICE LOCATION IS MISSING
2453	INVALID DIAGNOSIS TREATMENT INDICATOR
2454	INVALID ASSIGNMENT CODE
2456	INVALID PROCEDURE TYPE
2458	ALIEN MEMBER ON REVIEW
2459	REVENUE CODES OP401 & OP403 NEED HCPC CODE
2460	CANNOT DETERMINE THE INPATIENT LEVEL OF CARE
2461	OCCURENCE CODE SPAN MISSING/INVALID
2462	INVALID/MISSING SPAN DATE
2463	SPAN THRU DATE LESS THAN SPAN FROM DATE
2464	SPAN DATE CONFLICT WITH DATES OF SERVICE SHOWN
2465	SPAN DATES OVERLAP
2466	SPAN DATES DOES NOT EQUAL TOTAL LINE ITEM DAYS
2468	NAME ON CLAIM MUST MATCH DHS IDENTIFICATION
2469	LTC MEMBER NAME/ID MISMATCH
2470	NAME ON CLAIM MUST MATCH DHS IDENTIFICATION
2471	NDC IS DEACTIVED AND NOT PAYABLE ON DATE FILLED
2472	NAME ON CLAIM MUST MATCH DHS IDENTIFICATION
2473	NAME ON CLAIM MUST MATCH DHS IDENTIFICATION
2474	DATE DISPENSED AFTER BILLING DATE
2475	DATE DISPENSED AFTER ICN DATE
2476	MAXIMUM HOSPITAL DAYS FOR THIS ADULT HAS BEEN PAID
2477	THE DIAGNOSIS CODE IN SEQUENCE 10-24 IS IN AN INVALID FORMAT
2478	PCS MISSING SUBMITTED CHARGE
2479	CLIA OUT OF DATE
2485	DATE DISPENSED EARLIER THAN DATE PRESCRIBED
2486	INPATIENT PSYCHIATRIC NEEDS PRIOR AUTHORIZATION
2487	PRIMARY DIAG CODE DETOX/NO DETOX REVENUE CODE
2488	ADMIT DATE DOES NOT EQUAL FIRST DATE OF SERVICE
2489	NO CLIA - DOS PRIOR TO CLIA EFFECTIVE DATE
2490	INPATIENT SERVICES ARE NOT COVERED FOR THIS MEMBER
2491	DRUG NOT APPROVED
2492	NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE
2493	NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE
2494	NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE
2495	NO CLIA - DOS PRIOR TO CLIA EFFECTIVE DATE
2496	NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE
2497	NO CLIA - DOS PRIOR TO CLIA - EFFECTIVE DATE
2498	NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE
2499	TPL PAY CHASE IMMUNO SUPPRESS DRUG
2500	TPL - PAY AND REPORT
2501	SUSPEND FOR TPL REVIEW

2502	FILE CLAIM WITH MEDICARE
2503	THIS PATIENT HAS OTHER INSURANCE
2505	CLAIM DOCUMENTATION INDICATES OTHER INSURANCE PAYMENT WAS RECEIVED BY MEMBER OR IS NOT SUFFICIENT.
2507	EPSDT-MAY HAVE TPL
2508	TPL PAY AND CHASE PHARMACY
2509	TPL PAY AND CHASE PRE-NATAL
2510	THIS PATIENT HAS TWO COVERAGE TYPES
2518	PROVIDER TYPE - CLAIM INPUT CONFLICT
2519	DRUG REQUIRES PRIOR AUTHORIZATION
2520	DRUG QUANTITY PER DAY LIMIT HAS BEEN EXCEEDED
2522	MEMBER IS NOT ELIGIBLE FOR THESE SERVICES
2524	OVERNITE LABOR ROOM REQUIRES OCC CODE 51 AND DATE
2526	PCS PRIOR AUTHORIZATION NOT ON FILE
2527	PCS-NO UNITS AUTHORIZED-THESE DATES OF SERVICES
2528	PCS PRIOR AUTHORIZATION UNITS USED
2530	TIER 2 NSAID NO RECORD OF TIER 1'S ON FILE
2532	DISEASE STATE MANAGEMENT
2533	PDUR DRUG-ALLERGY INTERACTION
2534	PRODUR DRUG-AGE INTERACTION
2535	PDUR INGREDIENT DUPLICATION
2536	PDUR THERAPEUTIC DUPLICATION
2537	PDUR DRUG-TO-DRUG INTERACTION
2538	HMO CO-PAY/MEMBER HAS TPL
2539	PDUR EARLY REFILL ON PRESCRIPTION
2540	PDUR MINIMUM DURATION OF THERAPY
2541	PDUR DOSING PRECAUTION-HIGH DOSE
2542	PDUR DOSING PRECAUTION-LOW DOSE
2543	PDUR BREAST FEEDING/PREGNANCY PRECAUTION
2544	PDUR MAXIMUM DURATION OF THERAPY
2545	PDUR LATE REFILL ON PRESCRIPTION
2546	DRUG DISEASE MARKER
2547	HMO CO-PAY/MEMBER HAS MEDICARE
2548	PAY TO PROV FOR PROVIDER TYPE 63 MUST BE GROUP
2549	ADJUSTMENT SUSPEND FOR MANUAL REVIEW
2550	SERVICE NOT REFERRED BY PRIMARY CARE CASE MANAGER
2552	PROVIDER NOT ELIGIBLE TO PROVIDE SERVICE/MEDICAID
2555	CLAIM PAST 24 MONTH FILING - DTL
2556	MEMBER IS NOT WAIVER ELIGIBLE
2557	CLAIM PAST 24 MONTH FILING - HDR
2560	MEMBER SERVICES COVERED BY HMO PLAN
2561	PROVIDER INELIGIBLE FOR T19 SERVICES/HMO ONLY
2562	MEMBER PCPCM-CANNOT BILL OP/RHC/FQHC CLINICS RATE
2563	MEMBER NOT ENROLLED IN HMO FOR DOS
2564	SUPPLEMENTAL DELIVERY PYMT DENIAL CODE
2566	EXCEPTION CODE 566
2567	HMO CO-PAY/NO TPL OR MEDICARE COVERAGE
2569	CC CLAIMS CAN'T PROCESS THRU SYSTEM
2570	INVALID ELIGIBILITY FOR HMO COPAY
2571	CLAIMCHECK REBUNDLED
2572	CC INCIDENTAL TO PRIMARY PROCEDURE
2573	CC MUTUALLY EXCLUSIVE
2574	CLAIMCHECK COSMETIC SURGERY
2575	CLAIMCHECK DUPLICATE
2576	CC UNLISTED/OBSOLETE/EXPERIMENTAL/UNSPECIFIED
2577	CLAIMCHECK POSSIBLE DUPLICATE
2578	CLAIMCHECK PRE-OP/POST-OP
2579	CC GROUPHEALTH SMARTSUSPENSE SUSPEND
2580	CLAIMCHECK MEDICAL/EVALUATION VISIT
2581	MEMBER IS LOCKED-IN TO ANOTHER PHYSICIAN
2582	MEMBER IS LOCKED-IN TO ANOTHER PHARMACY
2583	CLAIMREVIEW NEW VISIT FREQUENCY
2584	CC GROUPHLTH SMARTSUSPENSE DENY
2587	CLAIMREVIEW INTENSITY OF SERVICE
2588	STOP LOSS NOT APPROVED
2589	CC INVALID MODIFIER/PROCEDURE COMBINATION
2590	CLAIMCHECK EXCEEDS 40 LINES
2591	CLAIMREVIEW MULTIPLE/DUPLICATE COMP.BILLING
2592	CLAIMCEHCK AGE REPLACEMENT
2593	CLAIM REVIEW DIAGNOSIS TO PROCEDURE
2594	CLAIMCHECK-BILL EACH DOS ON A SEPARATE LINE
2595	CLAIMCHECK AGE CONFLICT
2597	CLAIMCHECK MULTIPLE SURGERY
2598	CC-MULTIPLE SURGERY-DOUBLE MODIFIERS
2599	STOP LOSS THRESHOLD REACHED
2600	UNITS NOT EQUAL TO TEETH BILLED
2601	PART A CROSSOVER SPANS 20020501
2602	UNITS NOT EQUAL TO TEETH BILLED
2603	PROV ID ON CLAIM DOES NOT MATCH PROV ID ON PA
2604	SERVICE AND/OR DATES DO NOT MATCH PRIOR AUTH
2605	PRIOR AUTH FUND AND CLAIM FUND DOES NOT MATCH
2606	PRIOR AUTH UNITS/AMOUNTS USED
2609	CHECK CLAIM ATTACHMENT
2612	TOOTH NUM ON CLAIM DOES NOT MATCH TOOTH NUM ON PA
2614	DIAG CODE MISSING/NOT ON FILE-INPATIENT CLAIMS
2615	CLINIC RATE NOT ON FILE FOR HOSPITAL
2616	PROCEDURE NOT COMPENSABLE FOR ASSISTANT SURGEON
2618	AUTH SERVICES-MEMBER NOT ELIG
2619	MEMBER INELIGIBLE PAY (AUTH EXAM) FROM STATE FUND
2620	MEDICARE ADJUSTED CLAIM-SUBMIT PAPER XOVER CLAIM
2622	MASS CREDIT/ADJ BEING SUSPEND
2623	ADJUSTMENT HAS AUTO DENIAL
2625	FUND CODE UNDETERMINED
2627	COVERED FOR ORAL PATH ONLY
2628	DRUG REQUIRES PRIOR AUTHORIZATION/MN
2630	DIAGNOSIS NOT IN SCOPE OF DCYS PROGRAM
2631	DIAGNOSIS NOT IN SCOPE OF CCP PROGRAM

2632	DIAGNOSIS NOT IN SCOPE OF CN PROGRAM
2633	DIAGNOSIS NOT IN SCOPE OF MN PROGRAM
2634	DETAIL ATTENDING PHYSICIAN ID INVALID
2635	DETAIL FIRST OTHER PHYSICIAN ID INVALID
2636	DETAIL SECOND OTHER PHYS ID INVALID
2638	DRUG REQUIRES MEDICAL REVIEW/CN
2639	DRUG REQUIRES MEDICAL REVIEW/MN
2642	INVALID PROVIDER NUMBER
2643	ABORTION REQUIRES REVIEW
2644	PROCEDURE CODE MODIFIER NOT PAYABLE
2646	PROVIDER RATE NOT ON FILE
2648	CC SITE SPECIFIC MODIFIER-FILE ON SEPARATE LINE
2649	FILE SEPARATE CLAIMS FOR JUNE/JULY HOSPITAL DAYS
2651	INVALID TREATMENT DIAGNOSIS INDICATOR
2652	PCS-INVALID NET CLAIM CHARGE
2653	MEMBER ID IS INVALID FOR AUTH EXAM
2654	MEMBER ID IS INVALID FOR AUTH EXAM PAY STATE FD
2655	ELIG CHANGES/FILE SEPARATE CLAIMS FOR EACH MONTH
2657	POTENTIAL DISABILITY CLAIM
2659	DATE OVER 1 YR MORE THAN 90 DAYS AFTER MEDICARE PD
2660	ZERO AMOUNT TO PAY
2673	SUBMIT PAPER CLAIM
2681	PROVIDER INELIGIBLE ON DATE OF SERVICE
2696	CROSSOVER PART A NOT PAYABLE MEDICALLY NEEDY
2697	QMB MEMBER ELIGIBLE FOR CROSSOVER ONLY
2701	PHYSICAN SIGNED CONSENT FORM BEFORE STERILIZATION
2702	DATE OF SURGERY ON CONSENT FORM IS NOT ON CLAIM
2703	MEMBER UNDER 21 WHEN SHE SIGNED CONSENT FORM
2704	REQUIRES ADDRESS FOR FACILITY FOR STERILIZATION
2705	STERILIZATION CONSENT FORM IS NOT LEGIBLE
2706	DATE ON THE CONSENT FORM IS NOT LEGIBLE
2707	STERILIZATION/HYSTERECTOMY CONSENT FORM IS MISSING
2708	PATIENT NAME ON CONSENT FORM DOES NOT MATCH CLAIM
2709	CONSENT LESS THAN 30 DAYS BEFORE STERILIZATION
2710	CONSENT MORE THAN 180 DAYS BEFORE STERILIZATION
2711	STERILIZATION CONSENT FORM NOT DATED BY PHYSICIAN
2712	CONSENT FORM IS NOT SIGNED BY THE MEMBER
2713	CONSENT FORM IS NOT SIGNED BY THE COUNSELOR
2714	CONSENT FORM DOES NOT HAVE DATE COUNSELOR SIGNED
2715	STERILIZATION CONSENT FORM IS INCOMPLETE
2716	HYSTERECTOMY CONSENT FORM REQUIRED
2717	STERILIZATION CONSENT FORM NOT SIGNED BY PHYSICIAN
2718	INVALID SURGICAL PROCEDURE CODE
2719	REFILE CLAIM WITH OPERATIVE REPORT
2720	INCORRECT MEMBER DATE OF BIRTH ON CONSENT FORM
2721	FURTHER DESCRIPTION OF SERVICE REQUIRED
2722	STRENGTH AND DOSAGE OF INJECTION MEDICATION REQ
2723	SERVICES REQ DOCUMENTATION FOR MEDICAL NECESSITY
2724	REFILE CLAIM WITH CONSULTATION/PROGRESS NOTES
2725	SERVICE NOT COVERED AS BILLED
2726	REFERRING PHYSICIAN REQUIRED
2727	ANOTHER PROVIDER HAS BEEN PAID FOR THESE SERVICES
2728	SERVICES ARE NOT AUTHORIZED
2729	DENIED AFTER SPECIAL REVIEW
2730	HYSTERECTOMY CONSENT FORM SIGNED AFTER SURGERY
2732	COUNSELOR SIGNED CONSENT FORM PRIOR TO MEMBER
2733	SERVICES/SUPPLY NOT IN SCOPE OF PROGRAM
2734	PROCEDURE/REVENUE CODE-REQUIRE PRIOR AUTHORIZATION
2735	MEMBER INELIGIBLE ON SERVICE DATES
2736	MODIFIER ADDED/DELETED DUE TO MEDICAL REVIEW
2737	INVALID MODIFIER FOR THIS PROCEDURE
2738	INVALID PROCEDURE CODE USE VALID CPT OR HCPC CODE
2739	ONE AMBULATORY SURGERY ALLOWED PER DAY
2740	INVALID CODE FOR NARRATIVE DESCRIPTION
2741	INVALID SUBMITTED CHARGE
2742	AUTHORIZED PHYSICAL REQUIRES ABCDM-16
2743	EXCEPTION CODE 743
2744	AUTHORIZED PHYSICAL DOES NOT MATCH ABCDM-16
2745	REQUESTED ADDITIONAL INFORMATION NOT RECEIVED
2746	DENTAL X-RAYS ARE REQUIRED
2747	SERVICES ARE INCLUDED IN TOTAL PAID OB CARE
2748	PROCEDURE IS AN INCIDENTAL TO PAID MAJOR SURGERY
2749	OUTSIDE THE GUIDELINES OF THE MEDICAL PROGRAM
2750	EXCEEDS SUPPLY LIMIT/1 MONTH WITHIN 12 MONTHS
2751	EXCEPTION CODE 751
2752	PER PHY MANUAL-USE 99202 ANTEPART WHEN NOT TOT. OB
2753	PROCEDURE IS INCIDENTAL MAJOR PROCEDURE ON CLAIM
2754	REFILE USING "MEMBER AREA" IN SQ CM
2755	REFILE CLAIM WITH PROOF OF TIMELY FILING ATTACHED
2756	EXCEPTION CODE 756
2757	TAKE HOME MEDICATION IS NOT PAYABLE
2758	PROVIDER NAME DOES NOT MATCH PROVIDER NUMBER
2759	NEEDS COUNTY ADMIN AND/OR PROVIDER SIGNATURE
2760	MEMBER IS DECEASED THIS DATE OF SERVICE
2761	NAME ON SUBMITTED CLAIM DOES NOT MATCH DHS FILE
2762	FILE AN ASSIGNED MEDICARE CLAIM ON THIS PATIENT
2763	PCS - HEALTH CARE AUTHORITY WILL PROCESS CLAIM
2764	DUPLICATE OF PAID CLAIM
2765	INVALID HYSTERECTOMY CONSENT FORM
2766	STERILIZATION/HYSTERECTOMY CONSENT FORM IS INVALID
2767	EXCEPTION CODE 767
2768	REQUEST ADJUSTMENT TO PAID CLAIM-PER MANUAL
2769	PAYMENT CORRECTED/SPENDDOWN-ADM12-HIST ONLY ADJUST
2770	INSURANCE PAYMENT MORE THAN ALLOWABLE
2771	SERVICE NOT PAYABLE THIS DATE OF SERVICE
2772	TYPE OF BILL-CLAIM CONFLICT

2773	AUTHORIZED ROOM & BOARD SERVICES ARE NOT ON CLAIM
2774	EXCEPTION CODE 774
2775	CLAIM HAS BEEN FORWARED TO HCA
2777	SHOW MEDICARE PART B PAYMENTS
2778	HEALTH CARE AUTHORITY PROCESSED ADM12
2779	ELIGIBILITY PROBLEM PROCESSED BY DHS
2780	RESUBMIT WITH APPROPRIATE VALUE CODE AND UNITS
2781	ANOTHER DDS PAID THIS SERVICE IN PREVIOUS 12 MONTH
2782	PART OF INPATIENT HOSPITAL CHARGES
2783	PROCEDURE INCLUDED IN OFFICE CALL
2785	ANOTHER PHARMACY PAID FOR THIS PRESCRIPTION
2786	SAME NDC/DATE PAID THIS PHARM
2787	ASST SURGEON MUST FILE OWN CLM
2788	CLINIC VISIT PAID THIS DATE
2789	PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN
2790	ABCDM-16/CLAIM PROV CONFLICT
2791	INVALID DIAGNOSIS FOR DESCRIPTION
2792	STERILIZATION CONSENT REQUIRED
2793	SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE
2794	PAID CLAIM INCLUDED THIS PROCEDURE
2795	CC MUTUALLY EXCLUSIVE
2796	PATIENT HAS PRIVATE INSURANCE
2797	MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS
2798	REFILE WITH MEDICARE RECHECK HIC NUMBER
2799	EXCEPTION CODE 799
2800	PHARMACY-EXACT DUPLICATE OF ANOTHER CLAIM
2801	PHARMACY-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2802	PHARMACY-POSSIBLE CONFLICT OF ANOTHER CLAIM
2803	DENTAL-EXACT DUPLICATE OF ANOTHER CLAIM
2804	DENTAL-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2806	PRACTITIONER-EXACT DUPLICATE OF ANOTHER CLAIM
2807	PRACTITIONER-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2808	MEMBER IS ELIGIBLE FOR HOSPICE FOR A PORTION OF THE DATES OF SERVICE BILLED. PLEASE CORRECT AND RESUBMIT.
2812	CROSSOVER-EXACT DUPLICATE OF ANOTHER CLAIM
2813	EXCEPTION CODE 813
2814	CROSSOVER-POSSIBLE CONFLICT OF ANOTHER CLAIM
2815	LTC-EXACT DUPLICATE OF ANOTHER CLAIM IN SYSTEM
2816	LTC-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2820	PCS-EXACT DUPLICATE OF ANOTHER CLAIM
2821	PCS-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2822	EXCEPTION CODE 822
2823	OUTPATIENT-EXACT DUPLICATE OF ANOTHER CLAIM
2824	OUTPATIENT-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2826	HOME HEALTH-EXACT DUPLICATE OF ANOTHER CLAIM
2827	EXCEPTION CODE 827
2828	HOME HEALTH-POSSIBLE CONFLICT OF ANOTHER CLAIM
2829	INPATIENT-EXACT DUPLICATE OF ANOTHER CLAIM
2830	INPATIENT-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2831	EXCEPTION CODE 831
2832	TRANSPORTATION-EXACT DUPLICATE OF ANOTHER CLAIM
2833	TRANSPORTATION-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2835	CHIROPRACTOR-EXACT DUPLICATE OF ANOTHER CLAIM
2836	CHIROPRACTOR-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2838	LAB/XRAY-EXACT DUPLICATE OF ANOTHER CLAIM
2839	LAB/XRAY-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2842	DEALER-EXACT DUPLICATE OF ANOTHER CLAIM
2843	DEALER-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2845	OPTOMETRIST-EXACT DUPLICATE OF ANOTHER CLAIM
2846	OPTOMETRIST-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2849	INVALID MODIFIER COMBINATION
2850	LTC/INPT POSSIBLE CONFLICT WITH INPT/LTC CLAIM
2851	LTC-HOME HEALTH CLAIM CONFLICT
2852	LTC-PCS POSSIBLE CONFLICT
2853	PCS-LTC POSSIBLE CONFLICT
2854	INPATIENT-PCS POSSIBLE CONFLICT
2855	PCS-INPATIENT POSSIBLE CONFLICT
2856	HH/INPT POSSIBLE CONFLICT WITH INPT/HH CLAIM
2857	INPT/CROSSOVER POSSIBLE CONFLICT CROSSOVER/INPT
2858	INPT/OUTPT POSSIBLE CONFLICT WITH OUTPT/INPT CLAIM
2859	EXCEPTION CODE 859
2860	CROSS CLAIM TYPE J CODE CONFLICT
2877	REVIEW EDITS 4005/4006/4009/4084 PRIOR TO CUTBACK
2880	PRODEDURE CODE NOT VALID FOR FORM
2881	HOME HEALTH-LTC CLAIM CONFLICT
2882	LTC/XOVER POSSIBLE CONFLICT WITH XOVER/LTC CLAIM
2883	CROSSOVER-PCS POSSIBLE CONFLICT
2884	PCS-CROSSOVER POSSIBLE CONFLICT
2889	PART-A COINSURANCE GREATER MEDICARE PD AMT
2890	REVIEW CROSSOVER PART B COINSURANCE OVER $1000.00
2893	EXCEPTION CODE 893
2894	RURAL HEALTH REVENUE REQUIRES HCPC CODE
2895	RURAL HEALTH CLINIC REQUIRES REVENUE OP521
2896	FILE SEPARATE CLAIMS FOR DIFFERENT YEARS
2900	PCS DAYS REDUCED-INPT/LTC CONFLICT
2901	FILE SEPARATE CLAIM FOR REMAINING UNPAID DAYS
2903	MULTIPLE CPT CODES REQUIRED
2904	DENIED FOR OKLA FOUNDATION FOR PEER REVIEW AUDIT
2905	REFILE SEPARATE CLAIM FOR EACH MONTH
2906	MEDICARE DEDUCTIBLE APPLIED IN PREVIOUS 60 DAYS
2907	PAY TO GROUP HAS BEEN PAID FOR THIS SERVICE
2908	ANOTHER PROVIDER WITHIN GROUP PAID FOR SERVICE
2909	FILE SEPARATE CLAIM FOR SEPTEMBER AND OCTOBER
2910	PSYCHIATRIC ADMIT AFTER 9/1/92 NEEDS PA
2911	SERVICE PREVIOUSLY PAID ON GROSS ADJUSTMENT
2912	CLAIM HAS BEEN ADJUSTED AFTER SPECIAL REVIEW
2913	CLAIM HAS BEEN ADJUSTED AFTER MEDICAL REVIEW

2914	SERVICE PREVIOUSLY PAID ON PROVIDER ALTERNATE NUM
2915	PAID TO ANOTHER PROVIDER IN GROUP ON ALTERNATE NUM
2916	EXCEPTION CODE 916
2917	CHARGES INDICATE ERROR IN MATH
2918	INDICATE UNITS WORKED NOT DAYS
2919	FILE SEPARATE CLAIM FOR EACH DATE OF SERVICE
2920	WAIVERED SERVICE/DATES NOT ON PRIOR AUTHORIZATION
2921	LIST EACH DATE SEPARATELY
2922	PATIENT RECEIVED SETTLE/BILL PATIENT
2923	ITEMIZE CHARGES FOR SUPPLIES
2924	CLIENT RESPONSIBLE EXCEEDS ALLOWABLE
2925	MEDICAL CONDITION/DIAGNOSIS NOT COVERED
2926	DME NAME BRAND DOES NOT MATCH ORDER NUMBER
2927	INDICATE EXACT UNITS PROVIDED FOR MEMBER
2928	WHOLESALER'S INVOICE REQUIRED FOR PAYMENT
2929	PROC/DIAG REQUIRE FEDERAL MANDATED STATMT-ABORTION
2930	PROCEDURE UNITS REDUCED TO ALLOWABLE
2931	EXCEPTION CODE 931
2932	DUPLICATE OF PREVIOUSLY PAID CROSSOVER CLAIM
2933	ORIGINAL CLAIM BEING ADJUSTED-ALLOW 30 DAYS
2934	CLAIM WAS FILED WITH INVALID PROVIDER NUMBER
2935	RENTAL PREVIOUSLY PAID FOR THIS ITEM THIS MONTH
2936	CONTACT CASE MANAGER OR SUPERVISOR
2937	PROVIDER NOT ELIGIBLE THIS PROCEDURE CODE
2938	EXCEPTION CODE 938
2939	REFILE ON PAPER CLAIM
2940	SUBMIT PAPER CLAIM WITH NARRATIVE FOR PRICING
2941	REFILE WITH MEDICARE REMITTANCE STATEMENT
2942	DUPLICATE PAID THRU FINANCE
2943	REFILE ON ADM84-TRANSPORTATION CLAIM FORM
2944	DENIED AFTER CLAIM CHECK REVIEW
2945	INVALID PROOF OF DENIAL/HMO
2946	INVALID PROOF OF INSURANCE DENIAL
2947	REFILE WITH CORRECT ADMIT DATE
2948	RESUBMIT LEGIBLE CLAIM/ATTACHMENT
2949	EXCEPTION CODE 949
2950	THIS LEVEL TRANSPORTATION NOT REQUIRED
2951	DDSD WILL PROCESS CLAIM THROUGH FINANCE
2952	REFILE-NAME BRAND & PRODUCT/ORDER NUMBER FOR PRICE
2953	REFILE AS CROSSOVER WITH EOMP
2954	REFILE WITH APPROPRIATE EOMP
2955	NOT ELIGIBLE FOR WAIVERED SERVICES
2956	TPL PAID COLLECT FROM PATIENT
2957	NOT VERIFIED BY OPERATIVE REPORT
2958	ITEMIZE SURGERIES PER OPERATIVE REPORT
2959	CANNOT PROCESS NEGATIVE AMOUNTS
2960	ADJUSTED PER OFPR RECOMMENDATION
2961	NON EMERGENCY SERVICES NON PAYABLE FOR ALIEN
2962	DOCUMENT OF NECESSITY/MRI REPORT REQUIRED
2963	DOCUM DOES NOT JUSTIFY THE BILLED PROCEDURE
2964	REFILE CLAIM AS LIMIT TARGETED OB ULTRASOUND
2965	PAY REMAINING DAYS ON PARAMETER FILE
2966	FILE MEDICARE PART A FOR INPATIENT SERVICES
2967	PROVIDER NOT QUALIFIED FOR TARGETED OB US INTERP
2968	REFILE AS PHARMACY WITH NATIONAL DRUG CODE
2969	NO MEDICAL JUSTIFICATION FOR TARGETED OB US
2970	SUBMIT PREVIOUSLY REQUESTED OB/US QUALIFICATION
2971	PARTIAL HOURS NON ACCEPTABLE
2972	NO MEDICAL JUSTIFICATION FOR REVERSAL/REMOVAL
2973	REFILE AS AMBULATORY SURGERY
2974	PRESCRIBING PROVIDER EXCLUDED
2976	HYSTERECTOMY REQUIRE SIGN DATE
2977	REFILE CLAIM WITH MEDICAL RECORD
2978	INPATIENT HOSPITAL CLAIM PAID THIS DATE OF SERVICE
2979	NURSING HOME CLAIMS PAID THIS DATE OF SERVICE
2980	PROCEDURE NOT PAYABLE FOR THIS AGE
2981	VERIFY PA FOR THIS PROCEDURE/DATE OF SERVICE
2982	REFILE WITH PHYSICIAN PROGRESS NOTES
2983	PROV ID ON CLAIM DOES NOT MATCH PROV ID ON PA
2984	DIAGNOSIS NOT PAYABLE FOR NURSE MIDWIFE
2985	PROVIDER IS SUSPENDED OR TERMINATED
2986	UNITS CANNOT BE GREATER THAN 999
2987	PRIOR AUTHORIZATION UNITS/AMOUNTS USED
2988	TB ONLY ELIGIBLE - NEED 'T' IN FORCE FIELD (FF)
2989	SERVICE AND/OR DATES DO NOT MATCH PRIOR AUTH
2990	SERVICES ALLOWED AS ENCOUNTER ON ALTERNATE NUMBER
2991	UNITS REDUCED PER DOCU/AFTER SURS REVIEW
2993	EXCEPTION CODE 993
2994	EXCEPTION CODE 994
2995	EXCEPTION CODE 995
2996	EXCEPTION CODE 996
2997	EXCEPTION CODE 997
2998	EXCEPTION CODE 998
2999	EXCEPTION CODE 999
3000	UNITS EXCEED AUTHORIZED UNITS ON PRIOR AUTHORIZATION MASTER.
3001	PRIOR AUTHORIZATION DOES NOT MATCH FOR THIS CLAIM DETAIL.
3003	SERVICE REQUIRES PRIOR AUTHORIZATION.
3006	DOLLARS EXCEED AUTHORIZED DOLLARS ON AUTHORIZATION MASTER.
3037	MEMBER NUMBER HAS BEEN DEACTIVATED
3201	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR PRIMARY DIAGNOSIS.
3202	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR SECOND DIAGNOSIS.
3203	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR THIRD DIAGNOSIS.
3204	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR FOURTH DIAGNOSIS.
3205	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR FIFTH DIAGNOSIS.
3206	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR SIXTH DIAGNOSIS.
3207	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR SEVENTH DIAGNOSIS.

3208	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR EIGHTH DIAGNOSIS.
3209	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR NINTH DIAGNOSIS.
3210	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TENTH DIAGNOSIS.
3211	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR ELEVENTH DIAGNOSIS.
3212	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWELFTH DIAGNOSIS.
3213	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR THIRTEENTH DIAGNOSIS.
3214	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR FOURTEENTH DIAGNOSIS.
3215	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR FIFTEENTH DIAGNOSIS.
3216	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR SIXTEENTH DIAGNOSIS.
3217	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR SEVENTEENTH DIAGNOSIS.
3218	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR EIGHTEENTH DIAGNOSIS.
3219	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR NINETEENTH DIAGNOSIS.
3220	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTIETH DIAGNOSIS.
3221	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTY-FIRST DIAGNOSIS.
3222	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTY-SECOND DIAGNOSIS.
3223	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTY-THIRD DIAGNOSIS.
3224	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTY-FOURTH DIAGNOSIS.
3225	CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTY-FIFTH DIAGNOSIS.
3226	CLAIM DETAIL DENIED. UNITS OF SERVICE EXCEED NCCI MUE LIMITATION FOR THIS DMESUPPLIER SERVICE. THIS DENIED SERVICE SHOULD NOT BE BILLED TO THE MEMBER.
3227	CLAIM DETAIL DENIED. UNITS OF SERVICE EXCEED NCCI MUE LIMITATION FOR THIS SERVICE. THIS DENIED SERVICE SHOULD NOT BE BILLED TO THE MEMBER.
3228	CLAIM DETAIL DENIED. UNITS OF SERVICE EXCEED NCCI MUE LIMITATION FOR THIS OUTPATIENT HOSPITAL SERVICE. THIS DENIED SERVICE SHOULD NOT BE BILLED TO THE MEMBE
3229	CLAIM/DETAIL DENIED. DIAGNOSIS CODE INVALID FOR THIS DRUG.
3230	MEDICAL DIRECTION FOR ANESTHESIA IS NOT COVERED.
3233	CLAIM/DETAIL DENIED. NOT ALLOWED TO SUBMIT EVV SERVICES.
3234	CLAIM/DETAIL DENIED. ATTACHMENT NOT RECEIVED.
3236	COINSURANCE + DEDUCTIBLE GREATER THAN ESTABLISHED LIMIT. PLEASE VERIFY THE AMOUNT(S) YOU ENTERED ARE CORRECT.
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.
3398	SERVICE(S) NOT COVERED BY KY MEDICAID. DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.
3399	SERVICE NOT COVERED FOR THE RENDERING PROVIDER NUMBER.
3400	RENDERING PROVIDER TYPE INVALID FOR GROUP/CLINIC
3402	THE FOLLOWING CODES ARE REIMBURSED THROUGH THE PHARMACY PROGRAM: A4206, A4210,A4250, A4252, A4253, A4256, A4258, A4259, E0607 AND E2100.
3404	THE BILLING PROVIDER IS NOT ENROLLED TO THE MCO.
3405	PATIENT ACCOUNT NUMBER MUST BE ENTERED IN THE MEDICAL RECORD NUMBER FIELD ON PROFESSIONAL AND INSTITUTIONAL ENCOUNTERS.
3406	DELIVERY DIAGNOSES INCOMPLETE WITHOUT A REPORT OF PREGNANCY WEEKS OF GESTATION.PLEASE RESUBMIT WITH DIAGNOSIS SUPPORTING EARLY ELECTIVE DELIVERY OR ON PAPER
3407	EARLY DELIVERY NOT PAYABLE FOR THIS DIAGNOSIS CODE(S). PLEASE RESUBMIT WITH MEDICAL DOCUMENTATION SHOWING REASON FOR EARLY DELIVERY.
3408	PHYSICIAN ADMINISTERED DRUG RATES ARE NOT ON FILE FOR THIS PROCEDURE CODE/NDC COMBINATION.
3409	PHYSICIAN ADMINISTERED DRUG (PAD) PROCEDURE CODE REQUIRES NDC.
3410	NDC NOT VALID FOR PHYSICIAN ADMINISTERED DRUG (PAD) PROCEDURE CODE.
3411	NDC IS RATED DESI.
3412	NDC IS NOT REBATE-ELIGIBLE.
3413	NDC NOT VALID FOR DATE OF SERVICE.
3414	NDC IS OBSOLETE.
3415	UNITS OF SERVICE CANNOT EXCEED THE NUMBER OF DETAIL DAYS BILLED AND CANNOTINCLUDE DISCHARGE DATE.
3416	REVENUE CODE 169 MAY NOT BE BILLED WITH OTHER ACCOMMODATION REVENUE CODES.
3417	THE SCHOOL-BASED SERVICES DATA TO INDICATE THE SERVICE AS "EXPANDED ACCESS" CANNOT BE SUBMITTED IN THE DETAIL. THE EXPANDED ACCESS SERVICE INDICATOR "FREECAR
3580	THIS DRUG IS NOT COVERED FOR THIS PROVIDER.
3590	MODIFIER 33 IS ONLY BILLABLE WITH CERTAIN PROCEDURE CODES OR PROCEDURE CODE/DIAGNOSIS CODE/AGE/GENDER COMBINATIONS.
3591	MODIFIERS HM, U2, AND U6 ARE NOT BILLABLE ON PRIMARY CARE CENTER AND RURAL HEALTH CENTER CLAIMS.
3593	MODIFIER GT MUST BE BILLED WITH MODIFIER AH, AJ, SA, UA, U1, U2 OR U9. EFFECTIVE 1/1/2014 MODIFIER GT MUST BE BILLED WITH MODIFIER AF, AH, AJ, AM, HO, SA, U2
3594	DETAIL DENIED. BUCCAL AND FACIAL TOOTH SURFACES OR OCCLUSAL AND INCISAL TOOTH SURFACES NOT ALLOWED FOR SAME MEMBER, SAME PROVIDER, SAME DATE OF SERVICE, AND
3595	THE NUMBER OF UNITS BILLED FOR THIS PROCEDURE IS IN EXCESS OF THE THRESHOLD SETBY DMS TO AUTOMATICALLY INITIATE A SUSPENSION AND REVIEW OF THE CLAIM.
3596	TYPE OF BILL 110 NOT VALID FOR DRG CLAIMS.
3597	CLAIM/DETAIL DENIED. MFP MEMBER PLAN AND PROGRAM CODE DO NOT CORRESPOND. PLEASE CONTACT THE DEPARTMENT FOR MEDICAID SERVICES AT 502-564-5560.
3598	TOOTH NUMBER IS NOT VALID FOR PROCEDURE CODE AND PROVIDER TYPE.
3599	THIS SERVICE IS NOT COVERED WHEN PROVIDED BY A PHYSICIAN ASSISTANT.
3600	SERVICE NOT COVERED UNDER MEMBER'S PROGRAM.
3601	MEMBER'S ELIGIBILITY IS SUSPENDED DUE TO INCARCERATION.
3602	MEMBER IS ELIGIBLE BUT DIS-ENROLLED DUE TO ADDRESS MISMATCH.
3610	DETAIL DENIED. DATE OF SERVICE MUST BE EQUAL TO OR WITHIN SIX DAYS PRIOR TO MEMBER'S DATE OF DEATH.
3611	DETAIL DENIED. THIS REVENUE CODE REQUIRES THE ENTRY OF OCCURRENCE CODE 55 WITHA CORRESPONDING OCCURRENCE DATE INDICATING MEMBER'S DATE OF DEATH.
3612	PATIENT STATUS CODE 20, 40, 41, OR 42 MUST BE ENTERED ON HOSPICE CLAIMS WITH THIS REVENUE CODE.
3996	NDC IS TERMINATED.
3999	CLAIM BILLED WITH INACTIVE MID
4000	MORE THAN TWO SURGICAL UNITS ON THE CLAIM
4002	THIS NDC CODE IS NOT COVERED FOR THIS MEMBER.
4003	DRUG IS LESS THAN EFFECTIVE - DESI
4008	NDC IS OBSOLETE
4014	NO PRICING SEGMENT IS ON FILE.
4017	THIS DRG IS NOT COVERED FOR THIS MEMBER.
4019	PROCEDURE CODE REQUIRES ATTACHEMENT.
4020	UNITS BILLED EXCEED ALLOWABLE UNITS FOR THIS PROCEDURE CODE
4021	THIS PROCEDURE IS NOT COVERED FOR THIS MEMBER.
4026	NDC/DAYS SUPPLY LIMITATIONS. THIS NDC CODE BILLED MAY NOT BE GREATER THAN THE NUMBER OF DAYS ALLOWED ON THE NDC FILE.
4027	DIAGNOSIS CODE NOT COVERED FOR DATE OF SERVICE.
4029	DIAGNOSIS AND PLACE OF SERVICE DO NOT MATCH FOR THE MEMBER'S BENEFIT PLAN
4031	GENDER RESTRICTION FOR BILLED DIAGNOSIS.
4033	INVALID PROCEDURE CODE MODIFIER COMBINATION
4039	DIAGNOSIS CANNOT BE USED AS THE PRINCIPAL DIAGNOSIS
4047	FIFTH DIAGNOSIS CODE IS INVALID.
4048	SIXTH DIAGNOSIS CODE IS INVALID.
4049	SEVENTH DIAGNOSIS CODE IS INVALID.
4050	EIGHTH DIAGNOSIS CODE IS INVALID.
4051	NINTH DIAGNOSIS CODE IS INVALID.
4052	ADMITTING DIAGNOSIS CODE IS INVALID.
4060	E (EMERGENCY) DIAGNOSIS CODE IS INVALID.
4061	ADMITTING DIAGNOSIS CODE IS MISSING.
4063	ICD PROCEDURE CODE/AGE RESTRICTION.
4064	GENDER RESTRICTION FOR COVERED ICD PROCEDURE.
4065	ICD PROCEDURE REQUIRES ATTACHMENT.

4067	ICD SURGICAL PROCEDURE CODE INVALID FOR DATE OF SERVICE.
4070	MODIFIER RESTRICTION FOR REIMBURSEMENT RULE
4077	REVENUE CODE INVALID FOR DATE OF SERVICE.
4089	MISSING OR INVALID SURGERY CODE-PLEASE VERIFY TO SEE IF HCPC CODE CAN BE BILLED WITH THE SURGERY REVENUE CODE AND RESUBMIT
4095	NONSURGICAL SERVICES ARE NOT REIMBURSED INDIVIDUAL
4098	PRICING BEING REVIEWED
4107	REVENUE CODE IS NOT APPROPRIATE/NOT COVERED FOR THE "TYPE" OF SERVICE BEING PROVIDED
4108	NO ASC ON FILE
4114	PRICING BEING REVIEWED
4115	PRICING BEING REVIEWED
4119	VALUE CODE AMOUNT MISSING XYZ
4120	VALUE CODE IS MISSING
4121	PROCEDURE CODE REQUIRES TOOTH QUADRANT
4122	VALUE CODE IS INVALID
4123	VALUE CODE AMOUNT IS MISSING
4124	VALUE CODE AMOUNT IS INVALID
4127	CANNOT PRIORITIZE MEMBER'S PROGRAMS DUE TO SPAN-DATING. PLEASE RESUBMIT WITH EACH PROCEDURE CODE/SINGLE DATE OF SERVICE COMBINATION SUBMITTED ON A SINGLE LIN
4140	THIS PROVIDER MAY NOT BILL THIS SERVICE FOR THIS MEMBER.
4141	THIS PROCEDURE IS NOT COVERED FOR THIS MEMBER.
4142	THIS REVENUE CODE IS NOT VALID FOR THIS PROVIDER CONTRACT.
4188	THIS QUADRANT CODE IS NOT VALID FOR THIS PROCEDURE CODE.
4189	THIS ARCH CODE IS NOT VALID FOR THIS PROCEDURE CODE.
4203	THIS SERVICE IS A NON-COVERED OKLAHOMA HEALTH COVERAGE PROGRAM SERVICE AS THE RENDERING PROVIDER IS NOT RECOGNIZED BY THE OKLAHOMA HEALTH COVERAGE PROGRAM.
4207	CLIA NUMBER MISSING OR NOT ON FILE FOR DATE OF SERVICE.
4209	NO MATCHING PRICING SEGMENT FOR THE PROCEDURE/MODIFIER COMBINATION BILLED
4211	PROCEDURE CODE/TOOTH NUMBER COMBINATION IS MISSING OR INVALID.
4215	REVENUE CODE NOT VALID FOR THIS BILL TYPE
4218	INVALID PROCEDURE FOR CLAIM FORM
4220	EPOGEN REQUIRES VALUE CODE 68
4227	THIS REVENUE CODE IS NOT COVERED FOR THIS MEMBER.
4244	THIS DIAGNOSIS IS NOT COVERED FOR THIS MEMBER.
4246	ADJUSTMENT NET PAID AMOUNT EXCEEDS THE CASH RECEIPT BALANCE
4251	DECIMAL UNITS NOT BILLABLE FOR PROCEDURE.
4252	DIAGNOSIS CODE 10-24 NOT ON FILE
4253	REVENUE CODE REQUIRES MEDICAL REVIEW
4254	REVENUE CODE VS AGE RESTRICTION
4255	ONE OR MORE MODIFIERS ON THIS DETAIL CAN ONLY BE BILLED FOR MEMBERS AGED 21 AND YOUNGER
4257	THIS PROCEDURE CODE/MODIFIER COMBINATION IS NOT COVERED FOR THIS PROVIDER CONTRACT.
4260	ONE OR MORE OF THE EXTERNAL CAUSE OF INJURY DIAGNOSIS CODES IS INVALID.
4261	ONE OR MORE OF THE EXTERNAL CAUSE OF INJURY DIAGNOSIS CODES IS NOT ON FILE.
4262	ONE OR MORE OF THE PATIENT REASON FOR VISIT DIAGNOSIS CODES IS FORMATTED INCORRECTLY.
4264	ONE OR MORE OF THE PATIENT REASON FOR VISIT DIAGNOSIS CODES IS NOT ON FILE.
4312	PRIMARY DETAIL DIAGNOSIS CODE DOES NOT SUPPORT PROCEDURE CODE BILLED.
4314	DENIED. DIAGNOSIS CODE IS NOT COVERED.
4316	DIAGNOSIS CODE(S) DOES NOT SUPPORT PROCEDURE CODE BILLED.
4318	PRIMARY HEADER DX RESTRICTION FOR BILLED ICD PROCEDURE.
4321	PRIMARY HEADER DIAGNOSIS RESTRICTION FOR BILLED REVENUE CODE.
4322	DIAGNOSIS CODE NOT VALID FOR THIS REVENUE CODE.
4330	HEADER DIAGNOSIS(ES) DOES NOT SUPPORT SERVICE BILLED.
4331	DETAIL DIAGNOSIS(ES) DOES NOT SUPPORT SERVICE BILLED.
4332	HEADER DIAGNOSIS(ES) DOES NOT SUPPORT SERVICE BILLED.
4333	DETAIL DIAGNOSIS(ES) DOES NOT SUPPORT SERVICE BILLED.
4371	THIS SERVICE IS COVERED FOR QMB ONLY MEMBERS.
4374	DENIED. REVENUE CODE IS NOT COVERED.
4376	DENIED. ICD SURGICAL PROCEDURE CODE(S) IS NOT COVERED.
4381	NO REIMBURSEMENT RULE ON FILE.
4384	THE PRIMARY DIAGNOSIS ON THE CLAIM IS NOT VALID FOR DRG ASSIGNMENT.
4385	MEMBER PLAN - PROCEDURE NOT BILLABLE WITH REVENUE CODE
4386	PROVIDER CONTRACT - PROCEDURE NOT BILLABLE WITH REVENUE CODE
4387	REIMBURSEMENT - PROCEDURE NOT PAYABLE WITH REVENUE CODE
4391	THE LENGTH OF STAY ON THE CLAIM IS NOT VALID FOR DRG ASSIGNMENT.
4393	CONTRACT INVALID REVENUE/PROCEDURE COMBO
4394	UNABLE TO DETERMINE REGULAR MEDICAID CLAIM TYPE FOR CROSSOVER CLAIM
4395	PROVIDER CONTRACT - PROCEDURE - OOS NOT COVERED
4396	PROVIDER CONTRACT - REVENUE CODE - OOS NOT COVERED
4397	PROVIDER CONTRACT - DRG - OOS NOT COVERED
4398	PROVIDER CONTRACT - ICD9 PROC - OOS NOT COVERED
4400	THE NDC IS NOT NUMERIC OR NOT FOUND IN THE DRUG FILE
4401	THIS NDC IS NOT VALID FOR THE DRUG GROUP FOR THIS PROCEDURE
4402	THE NDC IS MISSING OR IS NOT VALID FOR THIS J-CODE
4403	THE NDC QUANTITY IS MISSING OR ZERO.
4404	AWP NOT ON FILE FOR NDC
4406	THIS PROCEDURE IS NOT COVERED FOR THIS MEMBER PLAN/AID CATEGORY.
4407	THIS REVENUE CODE IS NOT COVERED FOR THIS MEMBER PLAN/AID CATEGORY.
4408	A NATIONAL DRUG CODE (NDC) IS REQUIRED FOR THIS REVENUE CODE.
4409	DIAGNOSIS CODE(S) IS INVALID FOR DATE OF DISCHARGE.
4410	DIAGNOSIS CODE(S) IS INVALID FOR DATE OF ADMISSION.
4411	HEADER PICK-UP LOCATION INFORMATION IS MISSING OR INVALID.
4412	HEADER PICK-UP LOCATION ADDRESS LINE ONE IS MISSING.
4413	HEADER PICK-UP LOCATION CITY IS MISSING.
4414	HEADER PICK-UP LOCATION ZIP CODE IS MISSING OR INVALID.
4415	HEADER DROP-OFF LOCATION INFORMATION MISSING.
4416	HEADER DROP-OFF LOCATION ADDRESS LINE ONE IS MISSING.
4417	HEADER DROP-OFF LOCATION CITY IS MISSING.
4418	HEADER DROP-OFF LOCATION ZIP CODE IS MISSING OR INVALID.
4419	MCO PAID AMOUNT MISSING OR NOT GREATER THAN ZERO.
4420	MEMBER MANAGED CARE REGION CODE MISSING OR INVALID.
4421	ENCOUNTER SUBMITTER ID INVALID FOR THE DATE OF SERVICE
4422	THIS MEMBER HAS NO PLAN OF CARE SEGMENT FOR THE DATE OF SERVICE.
4423	THIS SERVICE IS NOT PAYABLE FOR WEEKEND DATES OF SERVICE.
4424	TENTH DIAGNOSIS CODE IS IN INVALID FORMAT.
4425	ELEVENTH DIAGNOSIS CODE IS IN INVALID FORMAT.
4426	TWELFTH DIAGNOSIS CODE IS IN INVALID FORMAT.
4427	TENTH DIAGNOSIS CODE IS NOT ON FILE.
4428	ELEVENTH DIAGNOSIS CODE IS NOT ON FILE.
4429	TWELFTH DIAGNOSIS CODE IS NOT ON FILE.

4430	THE ENCOUNTER DATA TYPE SUBMITTED IS NOT ACCEPTABLE FOR THE FILE TYPE.
4431	THIS PROCEDURE CODE IS NOT COVERED FOR THIS REVENUE CODE.
4432	NDC REQUIRED FOR THIS PROCEDURE CODE.
4433	TYPE OF BILL INVALID FOR CLAIM TYPE.
4434	MODIFIER 50 CANNOT BE BILLED WITH UNITS OF SERVICE GREATER THAN 1.
4435	MODIFIER U1 IS NOT VALID FOR PHYSICIAN CLAIMS FOR DATES OF SERVICE 10/01/2015 AND AFTER. PHYSICIAN ASSISTANT SERVICES FOR DATES OF SERVICE 10/01/2015 AND AFT
4436	MODIFIERS AS AND 80 CANNOT BE BILLED WITH MODIFIER SA.
4437	MODIFIER BILLED IS NOT COVERED FOR THIS PROVIDER TYPE.
4438	CLAIM REQUIRES DOCUMENTATION. PLEASE RESUBMIT ON PAPER. DOCUMENTATION REQUIRED DEPENDENT ON SPECIFIC REVENUE CODE AND CRITERIA SET FOR REVIEW.
4714	AGE RESTRICTION FOR BILLED PROCEDURE.
4715	AGE RESTRICTION FOR BILLED REVENUE CODE.
4750	REVENUE CODE NOT COVERED FOR THIS MEMBER AND TYPE OF BILL.
4760	MEDICAL REVIEW RESTRICTION FOR BILLED ICD PROCEDURE.
4765	THIS ICD PROCEDURE IS NOT COVERED FOR THIS MEMBER.
4801	THIS PROCEDURE IS NOT COVERED FOR THIS PROVIDER CONTRACT.
4802	THE PROVIDER IS NOT ALLOWED TO BILL THIS DIAGNOSIS
4804	THIS REVENUE CODE IS NOT COVERED FOR THIS PROVIDER CONTRACT.
4805	THIS DRG IS NOT COVERED FOR THIS PROVIDER CONTRACT.
4813	MUST SUBMIT SPECIFIC DOCUMENTATION WHICH SUPPORTS THE PROCEDURE BEING PERFORMEDIN THIS SETTING VS. THE PHYSICIAN OFFICE SETTING.
4831	NO REIMBURSEMENT RULE ON FILE.
4882	THIS DRG IS NOT COVERED FOR THIS MEMBER.
4886	DENIED. DRG IS NOT COVERED.
4975	THIS REVENUE CODE IS NOT COVERED FOR THIS MEMBER.
4980	MEMBER BENEFIT AND ASSIGNMENT PLANS CONFLICT WITH EACH OTHER.
4990	THIS PROCEDURE CODE IS NOT COVERED FOR THIS MEMBER.
5000	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5001	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5002	THIS ADJUSTMENT IS A DUPLICATE OF A PREVIOUS ADJUSTMENT.
5003	THIS IS A DUPLICATE OF ANOTHER CLAIM REVERSAL.
5004	REVERSAL NOT PROCESSED, NO MATCH FOUND ON RX NUMBER AND PROVIDER NUMBER. PLEASE REFER TO YOUR POS MANUAL.
5005	REVERSAL NOT PROCESSED- MULTIPLE MATCHES FOUND WITH SAME RX NUMBER, PROVIDER NUMBER AND DISPENSING DATE. PLEASE REFER TO YOUR POS MANUAL.
5007	THIS IS A DUPLICATE OF ANOTHER CLAIM. IF THIS CLAIM WAS INTENDED TO BE AN ADJUSTMENT, PLEASE SUBMIT THE APPROPRIATE ADJUSTMENT REQUEST FORM.
5010	EXACT DUPLICATE - TOOTH SURFACE
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
5200	VENI/ARTERIAL PUNCTURE SAME DATE OF SERVICE AS MONITORED PROCEDURE.
5203	CBC MAY NOT BE PAID ON SAME DAY AS CBC COMPONENTS.
5214	PROCEDURE CODES 93297 AND 93298 NOT ALLOWED SAME DOS.
5217	PROCEDURE CODES 93285 AND 93279, 93284 OR 93291 NOT ALLOWED SAME DOS.
5219	PROCEDURE CODE 93286 OR 93288 AND 93279-93281 NOT ALLOWED SAME DOS.
5221	PROCEDURE CODE 93287 OR 93289 AND 93282-93284 NOT ALLOWED SAME DOS.
5222	PROCEDURE CODE 93288 AND 93286, 93294, OR 93296 NOT ALLOWED SAME DOS.
5223	PROCEDURE CODE 93289 AND 93287, 93295 OR 93296 NOT ALLOWED SAME DOS.
5224	PROCEDURE CODE 93290 AND 93297 OR 93299 NOT ALLOWED SAME DOS.
5235	PROC S5100 & REV 580 NOT BILLABLE SAME MEMBER SAME DOS
5236	MONTHLY DIALYSIS NOT PAYABLE FOR SAME DATE OF SERVICE AS DAILY.
5237	PROCEDURE CODE 93293 AND 93294 NOT ALLOWED SAME DOS.
5241	PROCEDURES ARE NOT PAYABLE IN 30 DAYS OF RELATED PROCEDURES.
5242	PROCEDURE CODE 93291 AND 93288-93290, 93298 OR 93299 NOT ALLOWED SAME DOS.
5244	PROCEDURE CODE 93296 AND 93299 NOT ALLOWED SAME DOS.
5246	PROCEDURE CODES 93282 OR 93292 AND 93745 NOT ALLOWED SAME DOS.
5249	PROCEDURE CODE 93285 OR 93291 AND 33282 NOT ALLOWED ON THE SAME DOS.
5250	PROCEDURE CODE H0050 IS NOT ALLOWED ON THE SAME DOS AS PROCEDURE CODE H0001, 90791, 90792, 90845, 96105, 96110, 96111, 96116, 96125, 96150 OR 96151.
5263	RESPITE AND PERSONAL SERVICES CANNOT BE BILLED ON THE SAME DATE OF SERVICE AS RESIDENTIAL SERVICES.
5265	THERAPY SERVICES PERFORMED BY A THERAPIST CANNOT BE BILLED ON THE SAME DATE OFSERVICE AS THERAPY SERVICES PERFORMED BY A THERAPY ASSISTANT FOR SCL2 MEMBERS.
5267	PROCEDURE CODES H2019 AND H2020 NOT ALLOWED ON THE SAME DATE OF SERVICE, SAME MEMBER.
5269	09110/D9110 ON SAME DOS AS OTHER PROCEDURE.
5270	PROCEDURE CODE H2019 AND H2020 NOT ALLOWED ON THE SAME DATE OF SERVICE, SAME MEMBER.
5271	PAYMENT FOR PROCEDURE IS IN REIMBURSEMENT FOR SURGERY.
5272	PROCEDURE CODE NOT ALLOWED FOR DOS AS ADDITIONAL PROCEDURE.
5273	DETAIL DENIED. PROCEDURE CODE IS NOT ALLOWED FOR THE SAME MEMBER, SAME PROVIDER, SAME DATE OF SERVICE AS OTHER COVID-19 LAB PROCEDURE CODE BILLED.
5278	GENERAL SERVICES NOT PAYABLE ON SAME DOS AS SPECIAL.
5284	PROCEDURE CODE H2019 AND PROCEDURE CODE H2019, MODIFIER UG, ARE NOT ALLOWED ONTHE SAME DOS, SAME MEMBER.
5290	S5100 AND S5101 NOT BILLABLE SAME MEMBER SAME DOS
5292	HEMODIALYSIS NOT PAYABLE ON SAME DOS AS EVALUATION PROCEDURE.
5295	PROCEDURE CODES 00170 AND D9220 NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THESAME MEMBER.
5300	ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES.
5302	PERIODONTAL SACLING AND ROOT PLANNING (D4341) IS NOT ALLOWEDON SAME DATE OF SERVICE, SAME MEMBER, SAME PROVIDERAS PROPHYLAXIS (D1110, D1120, D1201) AND VICE V
5303	CLAIM DETAIL DENIED. HYSTERECTOMY PROCEDURE CODE 58565 IS NOT PAYABLE WHEN BILLED IN CONJUNCTION WITH PROCEDURE CODES 58555 OR 57800 AND VICE-VERSA.
5304	CLAIM DENIED. 29581 NOT PAYABLE ON SAME DATE OF SERVICE AS 29540 OR 29580.
5305	CLAIM DENIED. 36147 AND 36148 NOT PAYABLE ON SAME DOS AS 75791.
5306	CLAIM DENIED. 74261 AND 74262 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 74263, 76376, OR 76377.
5307	CLAIM DENIED. 87150 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 83890-83914.
5308	CLAIM DENIED. 88387 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 88388 OR 88329-88334.
5309	CLAIM DENIED. 74263 IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 76376, OR 76377.
5310	CLAIM DENIED. 92540 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92541, 92542, 92544, OR 92545.
5311	CLAIM DENIED. 92550 AND 92570 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92567 OR 92568.
5312	CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 33975, 33976, 33979, OR 33981-33983.
5313	CLAIM DENIED. 95905 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 95900-95904 OR 95934-95936.
5314	CLAIM DENIED. 64491 AND 64492 MUST BE BILLED IN CONJUNCTION WITH 64490 (SAME DATE OF SERVICE).
5315	CLAIM DENIED. 75557, 75559, 75561, 75563, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 76376 OR 76377.
5316	CLAIM DENIED. 64494 AND 64495 MUST BE BILLED IN CONJUNCTION WITH 64493 (SAME DATE OF SERVICE).
5317	CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 75557, 75559, 75561, OR 75563 (SAME DATE OF SERVICE).
5318	CLAIM DENIED. 88388 IS ONLY PAYABLE IN CONJUNCTION WITH 88329 THROUGH 88334 (SAME DATE OF SERVICE).
5319	CLAIM DENIED. PROCEDURE CODES A4351 AND A4352 ARE NOT PAYABLE ON THE SAME DATEOF SERVICE AS A4353.
5320	PROCEDURE CODES 99408 AND 99409 NOT PAYABLE ON SAME DATE OF SERVICE AS PROCEDURE CODE 99213.
5321	PROCEDURE CODE 99408 AND 99409 NOT ALLOWED ON THE SAME DATE OF SERVICE.
5322	PROCEDURE CODE G0390 IS PAYABLE ONLY WHEN BILLED IN CONJUNCTION WITH PROCEDURECODE 99291 ON THE SAME DATE OF SERVICE.
5323	REVENUE CODE 550 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159.
5324	PROCEDURE CODE 99417 MUST BE BILLED IN CONJUNCTION WITH 99205 OR 99215.
5400	MILEAGE, OXYGEN AND SUPPLIES PROC CODE MUST MATCH.
5417	FLUORIDE MUST BE BILLED IN CONJUSTION WITH PROPHY
5418	PROCEDURE CODE A4264 MUST BE BILLED WITH PROCEDURE CODE 58565.
5421	99292 MUST BE BILLED IN CONJUNCTION WITH 99291.

5422	PERI AND ROOT SCALING NOT ALLOWED SDOS AS PROPHY
5423	E AND M CODE MUST BE BILLED WITH PROCEDURE CODE 90832, 90834 OR 90837.
5424	PROCEDURE CODE 90785 MUST BE BILLED WITH ONE OF THE PSYCHIATRIC DIAGNOSTIC PROCEDURE CODES.
5425	PROCEDURE CODES 90833, 90836 AND 90838 MUST BE BILLED WITH PROCEDURE CODES IN RANGE 99201 THRU 99255, 99304 THRU 99337 OR 99341 THRU 99350.
5426	PROCEDURE CODE 90840 MUST BE BILLED WITH PROCEDURE CODE 90839.
5427	PROCEDURE CODE 99050 MUST BE BILLED WITH AN EVALUATION AND MANAGEMENT PROCEDURECODE.
5428	PROCEDURE CODE 90785 MUST BE BILLED WITH ONE OF THE PSYCHIATRIC DIAGNOSTIC PROCEDURE CODES.
5500	STEP THERAPY REQUIREMENTS NOT MET FOR THIS DRUG
5510	DUPLICATE CLAIM DPH AND OTHER PROVIDER
5607	DETAIL DENIED. PROCEDURE CODE PAID TO ANOTHER PROVIDER FOR THE SAME DATE OF SERVICE.
5632	LAP HYSTER NOT BILLABLE WITH OTHER HYSTER PROC
5700	CLAIM/DETAIL DENIED. THIS NCCI COLUMN 1 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO A PREVIOUSLY PAID NCCI COLUMN 2 PROCEDURE CODE. TO BE PAID FORT
5701	CLAIM/DETAIL DENIED. THIS NCCI COLUMN 2 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO AN NCCI COLUMN 1 PROCEDURE CODE. THIS DENIED SERVICE SHOULD NOT
5702	CLAIM/DETAIL DENIED. THIS NCCI COLUMN 1 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO A PREVIOUSLY PAID NCCI COLUMN 2 PROCEDURE CODE. TO BE PAID FORT
5703	CLAIM/DETAIL DENIED. THIS NCCI COLUMN 2 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO AN NCCI COLUMN 1 PROCEDURE CODE. THIS DENIED SERVICE SHOULD NOT
6055	LIMITATION OF 26 VISITS PER CALENDAR YEAR EXCEEDED.
6099	CLAIM DENIED. LIMIT OF 25 NDCS PER DETAIL EXCEEDED.
6189	CLAIM/DETAIL DENIED. 99407 IS LIMITED TO 2 UNITS PER CALENDAR YEAR, PER MEMBER.
6200	MEMBERS ARE LIMITED TO ONE (1) OPTHAMOLOGICAL EXAMINATION PER PROVIDER PER CALENDAR YEAR.
6205	ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO TWO PER MEMBER PER PROVIDER, PER CALENDAR YEAR.
6210	PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR. REIMBURSEMENT CUT BACK TO RATE FOR PROCEDURE CODE 99348.
6211	PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR, PER PROVIDER.
6217	CARDIOVASCULAR DEVICE EVALUATION CODE LIMITED TO ONE IN A 90 DAY TIME PERIOD.
6218	INTERROGATION DEVICE EVALUATION CODE LIMITED TO ONE IN A 30 DAY TIME PERIOD.
6220	CERTAIN MICHELLE P. WAIVER SERVICES ARE LIMITED TO 40 HOURS CUMMULATIVELY PER CALENDAR WEEK.
6232	PROCEDURE CODE A7048 IS LIMITED TO ONE PER CALENDAR MONTH PER MEMBER.
6234	PROCEDURE CODE H0031 IS LIMITED TO 40 UNITS (10 HOURS) PER STATE FISCAL YEAR.
6235	PROCEDURE CODE H0032 IS LIMITED TO 16 UNITS (4 HOURS) PER WEEK.
6236	DETAIL DENIED. PROCEDURE CODE IS LIMITED TO TWO EVERY 24 MONTHS.
6237	PROCEDURE CODE B4100 IS LIMITED TO 180 UNITS (OUNCES) PER CALENDAR MONTH.
6238	HOME DELIVERED MEALS ARE LIMITED TO ONE PER DAY, PER MEMBER.
6239	HOME DELIVERED MEALS ARE LIMITED TO 5 UNITS PER CALENDAR WEEK, PER MEMBER.
6257	PROCEDURE CODE S5100 IS LIMITED TO 200 UNITS PER CALENDAR WEEK PER MEMBER.
6258	DETAIL DENIED. ADULT DAY HEALTH AND/OR HOME AND COMMUNITY SUPPORTS SERVICES LIMITED TO $200 PER DAY PER MEMBER.
6259	PROCEDURE CODE T1016 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER.
6262	PROCEDURE CODE 99188 IS LIMITED TO 2 UNITS PER CALENDAR YEAR.
6263	REVENUE CODE 590 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER.
6264	PROCEDURE CODE T2040, MODIFIER HI, IS LIMITED TO TWO UNITS PER CALENDAR MONTH, PER MEMBER.
6265	TOTAL AMOUNT ALLOWED FOR ENVIRONMENTAL AND MINOR HOME ADAPTATION HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF CARE YEAR.
6266	TOTAL AMOUNT ALLOWED FOR GOODS AND SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF CARE YEAR.
6267	DETAIL DENIED. EXCEEDS THE $200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER.
6285	TOTAL AMOUNT ALLOWED FOR RESPITE SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVELOF CARE YEAR.
6289	DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER.
6304	DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO $4000.00 PER CALENDAR YEAR.
6305	ENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO $500.00 PER CALENDAR PER MEMBER.
6306	FINANCIAL MANAGEMENT IS LIMITED TO 8 UNITS PER MEMBER, PER PROVIDER, PER CALENDAR MONTH.
6307	DENTAL PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER.
6308	COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS.
6309	ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS.
6310	NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS.
6318	ENVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO $2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC WAIVER PROGRAM.
6319	FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS.
6320	THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY.
6321	PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS.
6323	OCCUPATIONAL THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR ABI LTC MEMBERS.
6324	SPEECH THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR ABI LTC MEMBERS.
6325	PHYSICAL THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR ABI LTC MEMBERS.
6326	RESPITE SERVICES ARE LIMITED TO 1,440 HOURS PER MEMBER, PER CALENDAR YEAR FOR ABI LTC MEMBERS.
6327	ADULT DAY HEALTH CARE IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS.
6328	CLAIM/DETAIL DENIED. PROCEDURE(S) LIMITED TO FOUR UNITS PER DATE OF SERVICE.
6329	PROCEDURE CODE D1208 IS LIMITED TO TWO UNITS PER YEAR.
6330	THIS PROCEDURE IS LIMITED TO ONE PER LIFETIME, PER MEMBER.
6331	THIS PROCEDURE IS LIMITED TO ONE PER LIFETIME, PER MEMBER, PER LOWER QUADRANT.
6332	DENTAL PROCEDURE CODE D1208 IS LIMITED TO TWO PER YEAR PER MEMBER.
6333	CLAIM DENIED. PROCEDURE CODES 64492 AND 64495 ARE EACH LIMITED TO ONE UNIT PERDAY.
6334	CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO 336 HOURS PER MEMBER, PERPROVIDER, PER 12 MONTHS.
6335	CLAIM/DETAIL DENIED. HOME MODIFICATIONS ARE LIMITED TO $2000.00 PER MEMBER, PER PROVIDER, PER 12 MONTHS.
6336	CLAIM/DETAIL DENIED. ONLY ONE UNIT OF SUPERVISED RESIDENTIAL CARE IS PAYABLE PER DAY, PER MEMBER, PER PROVIDER.
6337	CLAIM DETAIL DENIED OR PAYMENT REDUCED. RESPITE IS LIMITED TO $4000.00 PER 365DAYS FOR THIS MEMBER.
6338	ONLY ONE UNIT OF RESIDENTIAL SERVICES CAN BE BILLED PER DAY PER PROVIDER FOR ANSCL2 MEMBER.
6339	CERTAIN SCL2 SERVICES ARE LIMITED TO 64 UNITS CUMULATIVELY PER DAY FOR SCL2 MEMBERS.
6340	DAY TRAINING CANNOT BE BILLED MORE THAN 5 DAYS DURING A CALENDAR WEEK FOR AN SCL2 MEMBER.
6341	OCCUPATIONAL THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR AN SCL2 MEMBER.
6342	SPEECH THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR AN SCL2 MEMBER.
6343	PHYSICAL THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR AN SCL2 MEMBER.
6344	DAY TRAINING AND SUPPORTED EMPLOYMENT LIMITED TO 160 CUMULATIVE UNITS PER CALENDAR WEEK FOR AN SCL2 MEMBER.
6345	COMMUNITY ACCESS SERVICES ARE LIMITED TO 160 CUMULATIVE UNITS PER CALENDAR WEEKFOR SCL2 MEMBERS.
6346	TRANSPORTATION NON-RESIDENTIAL SERVICES ARE LIMITED TO $265.00 PER CALENDAR MONTH FOR AN SCL2 MEMBER.
6347	SHARED LIVING SERVICES ARE LIMITED TO $600.00 PER CALENDAR MONTH FOR SCL2 MEMBERS.
6348	VEHICLE ADAPTATION SERVICES ARE LIMITED TO $6000.00 PER 5 YEARS FOR AN SCL2 MEMBER.
6349	ENVIRONMENTAL ACCESSIBILITY SERVICES LIMITED TO $8000.00 PER LIFETIME FOR AN SCL2 MEMBER.
6350	T1005 IS LIMITED TO 3,320 UNITS OF SERVICE DURING AN SCL2 MEMBER'S PLAN OF CAREPERIOD.
6351	T1999 IS LIMITED TO $1800.00 DURING AN SCL2 MEMBER'S PLAN OF CARE PERIOD.
6352	H0023 IS LIMITED TO 1,320 UNITS OF SERVICE DURING AN SCL2 MEMBER'S PLAN OF CAREPERIOD.
6353	H0004 IS LIMITED TO 160 UNITS OF SERVICE DURING AN SCL2 MEMBER'S PLAN OF CARE PERIOD.
6354	H2015 IS LIMITED TO 576 UNITS OF SERVICE DURING AN SCL2 MEMBER'S PLAN OF CARE PERIOD.
6355	PROCEDURE CODES 90832, 90834, 90835, 90887 AND H0004 ARE LIMITED CUMULATIVELY TO 4 HOURS PER DAY PER MEMBER.
6356	PROCEDURE CODES 90832, 90834, 90835, 90887 AND H0004 ARE LIMITED CUMULATIVELY TO 16 HOURS PER CALENDAR WEEK PER MEMBER.
6357	PROCEDURE CODE T1023 IS LIMITED TO 5 UNITS PER CALENDAR MONTH PER MEMBER.
6358	PROCEDURE CODE 90853 IS LIMITED TO 12 UNITS PER DAY PER MEMBER.
6359	PROCEDURE CODE 90853 IS LIMITED TO 36 UNITS PER CALENDAR WEEK PER MEMBER.
6360	PROCEDURE CODE T2023 IS LIMITED TO 1 UNIT PER CALENDAR MONTH PER MEMBER.
6361	PROCEDURE CODE T2012 IS LIMITED TO 7 HOURS PER DAY PER MEMBER.
6362	PROCEDURE CODE S9480 IS LIMITED TO 3 HOURS PER DAY PER MEMBER.
6363	PROCEDURE CODE S9480 IS LIMITED TO 15 HOURS PER CALENDAR WEEK PER MEMBER.
6364	PROCEDURE CODE H2019, MODIFIER UG, IS LIMITED TO 16 UNITS PER DAY PER MEMBER.

6365	PROCEDURE CODE H2019, EXCLUDING MODIFIER UG, IS LIMITED TO 24 UNITS/DAY PER MEMBER.
6366	PROCEDURE CODE S9485 IS LIMITED TO TEN CONSECUTIVE DAYS.
6367	PROCEDURE CODE H2021, MODIFIERS HM, HN & HS, IS LIMITED CUMULATIVELY TO 16 UNITS/DAY.
6368	PROCEDURE CODE S5145 IS LIMITED TO ONE UNIT PER DATE OF SERVICE PER MEMBER.
6370	T2025 IS LIMITED TO $1,000.00 DURING AN SCL2 MEMBER'S PLAN OF CARE PERIOD.
6371	NEW PATIENT DOMICIARY, REST HOME, AND CUSTODIAL CARE SERVICES ARE LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS.
6377	PROCEDURE CODE 83655, MODIFIERS 33 AND U7, IS LIMITED TO ONE PER CALENDAR YEAR,PER MEMBER.
6378	MEMBERS 0 THRU 15 MONTHS OF AGE ALLOWED SIX EPSDT/WELL CHILD VISIT PROCEDURES WHEN BILLED WITH MODIFIERS 33 AND UA.
6379	CERVICAL CANCER SCREENING IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER.
6380	PROCEDURE CODE S9485 LIMITED TO ONE PER DAY, PER MEMBER.
6381	PROCEDURE CODE A6545 IS LIMITED TO TWO PER LEG PER MEMBER PER CALENDAR YEAR.
6383	ONE COLON CANCER SCREENING PROCEDURE ALLOWED WHEN BILLED WITH MODIFIERS 33 AND U7 PER CALENDAR YEAR, PER MEMBER.
6384	SPIROMETRY TESTING FOR ASSESSMENT AND DIAGNOSIS OF COPD IS LIMITED TO 1 PER CALENDAR YEAR, PER MEMBER.
6385	PROCEDURE CODE A5057 IS LIMITED TO 31 UNITS PER CALENDAR MONTH PER MEMBER. PRIOR AUTHORIZATION REQUIRED FOR UNITS EXCEEDING 31.
6386	ONE NUTRITION AND ONE PHYSICAL ACTIVITY COUNSELING PROCEDURE ALLOWED PER MEMBER, PER CALENDAR YEAR.
6387	PROCEDURE FOR CONTROLLING BLOOD PRESSURE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER.
6388	PROCEDURE CODE S8189 IS LIMITED TO TWO PER CALENDAR MONTH PER MEMBER.
6390	PROCEDURE CODE D1354 IS LIMITED TO 2 UNITS PER 6 CALENDAR MONTHS.
6391	PROCEDURE CODE D1354 IS LIMITED TO 2 UNITS PER QUADRANT PER MEMBER PER CALENDARYEAR.
6392	SERVICES ARE LIMITED TO 40 HOURS PER CALENDAR WEEK FOR MEMBERS IN THE MICHELLEPWAIVER PROGRAM.
6393	PROCEDURE CODE D1354 IS LIMITED TO TWO UNITS PER TOOTH PER MEMBER PER SIX MONTHS.
6394	PROCEDURE CODE A9276 IS LIMITED TO 31 UNITS PER MEMBER PER CALENDAR MONTH.
6395	PROCEDURE CODE A9278 IS LIMITED TO ONE UNIT PER MEMBER PER CALENDAR YEAR.
6396	PROCEDURE CODE A9277 IS LIMITED TO TWO UNITS PER MEMBER PER CALENDAR YEAR.
6397	PROCEDURE CODES D9222 AND D9223 ARE LIMITED CUMULATIVELY TO FOUR (4) UNITS PER DATE OF SERVICE, PER MEMBER.
6398	PROCEDURE CODE A4224 IS LIMITED TO FIVE UNITS PER CALENDAR MONTH PER MEMBER.
6399	PROCEDURE CODE A4225 IS LIMITED TO FIFTEEN UNITS PER CALENDAR MONTH PER MEMBER.
6401	THIS SERVICE IS LIMITED TO 6 UNITS PER SIX MONTHS.
6514	HOME HEALTH LIMITS EXCEEDED FOR 1 MONTH
6515	PROCEDURE CODE D9248 IS LIMITED TO ONE UNIT PER DAY, PER MEMBER.
6516	OCCUPATIONAL THERAPY SERVICES EXCEED THE 20 VISITS ALLOWED PER CALENDAR YEAR PER MEMBER. PRIOR AUTHORIZATION REQUIRED.
6517	PHYSICAL THERAPY SERVICES EXCEED THE 20 VISITS ALLOWED PER CALENDAR YEAR PER MEMBER. PRIOR AUTHORIZATION REQUIRED.
6518	SPEECH THERAPY SERVICES EXCEED THE 20 VISITS ALLOWED PER CALENDAR YEAR PER MEMBER. PRIOR AUTHORIZATION REQUIRED.
6519	OCCUPATIONAL THERAPY SERVICES EXCEED THE 30 VISITS ALLOWED PER CALENDAR YEAR PER MEMBER. PRIOR AUTHORIZATION REQUIRED.
6520	PHYSICAL THERAPY SERVICES EXCEED THE 30 VISITS ALLOWED PER CALENDAR YEAR PER MEMBER. PRIOR AUTHORIZATION REQUIRED.
6521	SPEECH THERAPY SERVICES EXCEED THE 30 VISITS ALLOWED PER CALENDAR YEAR PER MEMBER. PRIOR AUTHORIZATION REQUIRED.
6522	PROCEDURE CODE 87529 IS LIMITED TO TWO (2) UNITS PER DAY PER MEMBER.
6523	PROCEDURE CODES E0443 AND E0444 ARE LIMITED CUMULATIVELY TO ONE UNIT PER MONTH,PER MEMBER.
6524	PROCEDURE CODE A9274 IS LIMITED TO 12 UNITS PER CALENDAR MONTH, PER MEMBER.
6525	REVENUE CODE 905 IS LIMITED TO ONE UNIT PER DAY, PER MEMBER.
6526	PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER.
6527	MAXIMUM DOSAGES ALLOWED FOR PROCEDURE CODE S0190 PER DAY PER MEMBER HAS BEEN EXCEEDED.
6528	PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER.
6529	PROCEDURE CODE J2350 IS LIMITED TO 600 UNITS/MGS PER DAY PER MEMBER.
6530	PROCEDURE CODE IS LIMITED TO ONE UNIT PER MEMBER IN A 365 DAY TIME PERIOD.
6531	PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 49 DAY TIME PERIOD.
6532	PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD.
6533	H0038HQ LIMITED TO 8 UNITS PER DATE OF SERVICE PER MEMBER PER PROVIDER.
6536	PROCEDURE CODE A9277 IS LIMITED TO FOUR UNITS PER MEMBER PER CALENDAR YEAR.
6538	HOSPITAL RESERVE DAYS LIMITED TO 30 PER MEMBER PER CALENDAR YEAR.
6539	PROCEDURE CODE IS LIMITED TO ONE PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.
6540	PROCEDURE CODE IS LIMITED TO $6000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD.
6541	DENTAL PROCEDURE CODES D7961 AND D7962 ARE LIMITED CUMULATIVELY TO 4 UNITS PER DATE OF SERVICE, PER MEMBER.
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.
6660	THERAPEUTIC LEAVE DAYS GREATER THAN 14 CANNOT BE BILLED.
6661	PROFESSIONAL AND TECHNICAL COMPONENTS OF SERVICES ARE NOT PAYABLE WHEN THE COMPREHENSIVE SERVICE HAS BEEN PAID.
6700	FOLLOW-UP VISITS NOT PAYABLE WITHIN 10 DAYS OF SURGICAL PROCEDURE
6701	FOLLOW-UP VISITS NOT PAYABLE WITHIN 30 DAYS OF SURGICAL PROCEDURE
6702	FOLLOW-UP VISITS NOT PAYABLE WITHIN 45 DAYS OF SURGICAL PROCEDURE
6703	FOLLOW-UP VISITS NOT PAYABLE WITHIN 60 DAYS OF SURGICAL PROCEDURE
6704	FOLLOW-UP VISITS NOT PAYABLE WITHIN 90 DAYS OF SURGICAL PROCEDURE
6726	DENTAL PROPHY/FLUORIDE LIMITED TO 2 PER 351 DAYS
6737	CLAIM/DETAIL PAYMENT REDUCED. HEARING AIDS ARE LIMITED TO $800.00 PER EAR
6742	PROCEDURE CODE D1206 IS LIMITED TO ONE UNIT PER 90 DAYS.
6743	PROCEDURE CODE D1206 IS LIMITED TO TWO UNITS PER YEAR.
6744	THIS SERVICE IS LIMITED TO 64 UNITS PER DAY OR IN COMBINATION WITH OTHER SELECTED PROCEDURE CODES
6745	CLAIM DENIED. MEMBER LIMITED TO 2 DIAGNOSTIC ULTRASOUNDS PER 9 MONTHS. MEDICALNECESSITY MUST SUPPORT UNUSUAL CIRCUMSTANCES. DIAGNOSIS CODE MUST INDICATE MEDIC
6746	THIS PROCEDURE LIMITED TO 1 PER MEMBER PER FOUR YRS
6748	DENTAL VISITS ARE LIMITED TO 12 PER CALENDAR YEAR FOR MEMBERS 21 YEARS OF AGE AND OLDER (PER PROVIDER).
6749	S5100 LIMITED TO 24 UNITS PER CALENDAR DAY
6750	S5100 LIMITED TO 120 UNITS PER CALENDAR WEEK
6753	ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO TWO PER CALENDAR YEAR. REIMBURSEMENT CUT BACK TO RATE FOR PROCEDURE CODE 99213.
6754	PROCEDURE CODE H0040 IS LIMITED TO ONE PER CALENDAR MONTH PER MEMBER.
6755	CLAIM/DETAIL DENIED. MAXIMUM OF 30 HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER CALENDAR YEAR.
6760	MEMBER'S THERAPY SERVICES EXCEED THE 20 VISITS ALLOWED PER CALENDAR YEAR. PRIOR AUTHORIZATION REQUIRED.
6764	PROCEDURE CODE LIMITED TO 1 PER 12 MONTHS PER MEMBER, PER PROVIDER
6765	INITIAL VISIT LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS
6766	MAXIMUM OF 15 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER.
6767	PROCEDURE CODE LIMITED 2/TOOTH/LIFETIME/MEMBER
6770	EXTRACTIONS LIMITED TO 3 PER LIFETIME PER TOOTH.
6772	DETAIL DENIED. ONLY ONE EVALUATION AND MANAGEMENT PROCEDURE CODE ALLOWED PER DATE OF SERVICE.
6773	ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO TWO PER CALENDAR YEAR. REIMBURSEMENT CUT BACK TO RATE FOR PROCEDURE CODE 99213.
6774	PURCHASE LIMITED TO 1 PER 5 YEARS
6785	PROC CODE WEEKLY FREQUENCY ON PA HAS BEEN EXCEEDED
6786	PROC CODE MONTHLY FREQUENCY ON PA EXCEEDS
6787	REV CODE MONTHLY FREQUENCY ON PA HAS BEEN EXCEEDED
6788	REVENUE CODE 182 IS LIMITED TO A MAXIMUM OF 15 CONSECUTIVE DAYS
6789	REVENUE CODE 189 LIMITED TO 45 DAYS PER LIFETIME
6790	PROCEDURE CODE WEEKLY FREQUENCY ON PA HAS BEEN EXCEEDED.
6791	PROCEDURE CODE MONTHLY FREQUENCY ON PA HAS BEEN EXCEEDED.
6792	PROCEDURE CODE WEEKLY FREQUENCY ON PRIOR AUTHORIZATION HAS BEEN EXCEEDED.
6793	PROCEDURE CODE MONTHLY FREQUENCY ON PRIOR AUTHORIZATION HAS BEEN EXCEEDED.

6794	PROCEDURE CODE T1000 IS LIMITED TO NINETY-SIX (96) UNITS PER DAY, PER MEMBER, SAME OR DIFFERENT PROVIDER.
6795	PROCEDURE CODE T1000 IS LIMITED TO 8,000 UNITS (2000 HOURS) PER TWELVE (12) MONTH PERIOD, PER MEMBER, SAME OR DIFFERENT PROVIDER.
6796	PROCEDURE CODES 76700, 76705, 76770, 76775, AND G0389 ARE LIMITED TO 1 UNIT, CUMULATIVELY, PER CALENDAR YEAR, PER MEMBER.
6797	PROCEDURE CODES 77052, 77055, 77056, 77057, G0202, G0204, AND G0206 ARE LIMITEDTO 1 UNIT, CUMULATIVELY, PER CALENDAR YEAR, PER MEMBER.
6798	PROCEDURE CODES 80422, 82947-82948, 82950-82953, AND 83036 ARE LIMITED TO 1 UNIT CUMULATIVELY, PER CALENDAR YEAR, PER MEMBER.
6799	PROCEDURE CODES 87590-87592, 87850, 87800, 87081, 87210, 87070, AND 87077 ARE LIMITED TO 1 UNIT, CUMULATIVELY, PER CALENDAR YEAR, PER MEMBER.
6800	PROCEDURE CODES 86701-86703, 86689, AND 87390-87391 ARE LIMITED TO 1 UNIT, CUMULATIVELY, PER CALENDAR YEAR, PER MEMBER.
6801	PROCEDURE CODES 76977, 77078-77082, 78350-78351 AND G0130 ARE LIMITED TO 1 UNIT, CUMULATIVELY, PER CALENDAR YEAR, PER MEMBER.
6802	REVENUE CODE 180 IS LIMITED TO 5 UNITS PER CALENDAR YEAR FOR PRTF AND PRTF 2 CLAIMS.
6803	REVENUE CODE 183 IS LIMITED TO 14 UNITS PER CALENDAR YEAR FOR PRTF AND PRTF 2 CLAIMS.
6804	THIS PROCEDURE CODE IS LIMITED TO 1 UNIT EACH PER MEMBER, PER DATE OF SERVICE.
6805	H0035, H0015, AND S9480 ARE LIMITED TO 1 UNIT EACH PER MEMBER, PER DATE OF SERVICE.
6806	97003 AND 97004 NOT ALLOWED ON THE SAME DATE OF SERVICE.
6807	OCCUPATIONAL THERAPY IS LIMITED TO 20 VISITS PER MEMBER, PER CALENDAR YEAR.
6808	H0040 IS LIMITED TO 1 UNIT PER CALENDAR MONTH PER MEMBER.
6809	V2020 IS LIMITED TO ONE UNIT PER CALENDAR YEAR.
6810	EYEWARE CODES V2100 THRU V2499 ARE LIMITED TO 2 UNITS (CUMULATIVELY) PER CALENDAR YEAR.
6811	T2023 LIMITED TO 1 UNIT PER CALENDAR MONTH.
6812	PROCEDURE CODE A4606 LIMITED TO 4 PER CALENDAR MONTH.
6813	PROCEDURE CODE E0602 IS LIMITED TO ONE PER CALENDAR YEAR.
6814	PROCEDURE CODES 77052, 77055, 77056, 77057, G0202, G0204, AND G0206 ARE LIMITEDTO 1 UNIT, CUMULATIVELY, PER CALENDAR YEAR, PER MEMBER.
6815	THIS PROCEDURE CODE MUST BE BILLED IN CONJUNCTION WITH 90837.
6816	99355 IS LIMITED TO TWO UNITS PER DATE OF SERVICE, PER MEMBER.
6817	PROCEDURE CODE 99355 MUST BE BILLED IN CONJUNCTION WITH PROCEDURE CODE 99354.
6818	THIS PROCEDURE CODE IS LIMITED TO 1 UNIT OF SERVICE PER DATE OF SERVICE, PER MEMBER, PER PROVIDER.
6819	AIR AMBULANCE PROCEDURE CODES ARE ALL-INCLUSIVE AND CANNOT BE BILLED WITH OTHERPROCEDURE CODES FOR THE SAME DATE OF SERVICE.
6820	REVENUE CODES 551 AND 561 ARE LIMITED TO A TOTAL OF 16 UNITS (4 HOURS), CUMULATIVELY, PER DATE OF SERVICE, PER MEMBER.
6821	PROCEDURE CODE V2523 (CONTACT LENS) IS LIMITED TO 16 UNITS PER MEMBER, PER CALENDAR YEAR.
6822	CERTAIN PROCEDURE CODES ARE NOT PAYABLE WITHIN THE SAME CALENDAR WEEK AS H0020 OR H0047.
6823	THIS PROCEDURE CODE IS LIMITED TO ONE UNIT PER CALENDAR WEEK.
6824	THIS PROCEDURE CODE IS LIMITED TO 4 UNITS PER CALENDAR YEAR.
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
7244	MEDICAL VISIT DENIED
7245	PROCEDURE ADDED DUE TO NEW VISIT FREQUENCY CODE REPLACEMENT
7246	PROCEDURE REPLACED DUE TO INTENSITY OF SERVICE REPLACEMENT
7247	PROCEDURE ADDED DUE TO INTENSITY OF SERVICE REPLACEMENT
7248	INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS
7249	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT
7250	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT
7251	PROCEDURE IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR
7252	DIAGNOSIS 1 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC
7253	DIAGNOSIS 2 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC
7254	DIAGNOSIS 3 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC
7255	DIAGNOSIS 4 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC
7256	MODIFIER 51 INVALID FOR PRIMARY PROCEDURE
7257	MODIFIER 51 MISSING FOR NON-PRIMARY PROCEDURE
7258	REVIEW MODIFIER 51
7259	SPLIT DECISION WAS RENDERED ON EXPANSION OF UNITS
7260	MORE THAN 100 LINES WERE ELIGIBLE FOR CLAIMCHECK PROCESSING
7261	INVALID PROCEDURE CODE
7262	DOB CANNOT BE GREATER THAN DATE OF SERVICE
7263	DOS REQUIRED FOR PROCEDURE
7264	DOS CANNOT BE A FUTURE DATE
7265	BIRTHDATE CANNOT BE A FUTURE DATE
7266	AGE CANNOT BE GREATER THAN 124 YEARS
7267	ONLY ONE PROVIDER ALLOWED FOR CURRENT PROCEDURES
7268	PROVIDER IS REQUIRED FOR HISTORY PROCEDURES
7269	MODIFIER NOT VALID FOR THIS PROCEDURE

7270	INVALID MODIFIER/PROCEDURE CODE COMBINATION
7271	CURRENT PROCEDURE LINES MUST HAVE SAME PROVIDER ID
7272	DIAGNOSIS 1 MUST BE A VALID CODE
7273	DIAGNOSIS 2 MUST BE A VALID CODE
7274	DIAGNOSIS 3 MUST BE A VALID CODE
7275	DIAGNOSIS 4 MUST BE A VALID CODE
7276	DIAGNOSIS MUST BE A VALID CODE
7277	PROCEDURE LINE DIAGNOSIS MUST BE A VALID CODE
7278	INVALID DATE (DATE OF BIRTH)
7279	INVALID AMOUNT CHARGED
7280	CLAIM LEVEL PROVIDER OR PROCEDURE LINE PROVIDER IS REQUIRED
7281	DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE
7282	INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS
7283	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT
7284	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT
7285	PROCEDURE IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR
7286	DIAGNOSIS IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR
7287	DIAGNOSIS IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR
7288	SMARTSUSPENSE FLAG
7289	SMARTSUSPENSE MONITOR
7290	MODIFIER 51 DELETED FOR PRIMARY PROCEDURE
7291	MODIFIER 51 ADDED FOR NON-PRIMARY PROCEDURE
7292	CLAIM/DETAIL DENIED. PROCEDURE IS NCCI INCIDENTAL/MUTUALLY EXCLUSIVE.
7293	CLAIM/DETAIL DENIED. PROCEDURE CODE IS CCI MUTUALLY EXCLUSIVE.
7499	MEMBER LOCK-IN TO SPECIFIC PRESCRIBING PROVIDER
7500	YOUR CLAIM IS BEING REVIEWED
7501	YOUR CLAIM IS BEING REVIEWED.
7502	MEMBER LOCKED IN TO A SPECIFIC PROVIDER
7503	MISSING/INVALID PRODUR CONFLICT CODE. ALERT ON RESPONSE DOES NOT MATCH AN ALERT SET ON THE CLAIM. PLEASE USE APPROPRIATE DD, LD, HD, ER, LR, PA, PG, MC, TD
7504	MISSING/INVALID PRODUR INTERVENTION CODE. PLEASE USE M0, P0 OR R0 AND RESUBMIT.
7505	MISSING/INVALID PRODUR OUTCOME CODE. PLEASE USE 1A-1G, 2A OR 2B.
7506	RESPONSE CLAIM. ORIGINAL CLAIM FAILED A NON-OVERRIDEABLE ALERT. CONTACT COLLEGE OF PHARMACY TO RECEIVE PRIOR AUTHORIZATION.
7507	VALID OUTCOME CODE OF "NOT FILLED" RECEIVED. RESPONSE ACCEPTED, CLAIM REJECTED.
7508	Quantity dispensed on response claim same as original claim
7509	RENDERING PROVIDER ON PREPAYMENT REVIEW
8000	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO BILLING ERROR.
8001	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO CHANGE IN OTHER.
8002	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO CHANGE IN MEDICARE.
8003	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO KEYING ERROR.
8004	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO PATIENT LIABILITY.
8005	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO SPENDDOWN.
8006	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO MISCELLANEOUS ERROR.
8007	PROVIDER REQUESTED CLAIM ADJUSTMENT DUE TO BILLING ERROR.
8008	PROVIDER REQUESTED CLAIM ADJUSTMENT DUE TO MISC. OR UNSPECIFIED ERROR
8019	PROVIDER REQUESTED A FULL OFFSET DUE TO A MISCELLANEOUS OR UNSPECIFIED ERROR.
8020	SURS INITIATED A FULL OFFSET DUE TO A DUPLICATE PAYMENT.
8021	SURS INITIATED A FULL OFFSET DUE TO WRONG PROVIDER.
8022	SURS INITIATED A FULL OFFSET DUE TO WRONG MEMBER NUMBER.
8023	SURS INITIATED A FULL OFFSET DUE TO WRONG NDC/PROCEDURE CODE/MODIFIER CODE
8024	SURS INITIATED A FULL OFFSET DUE TO WRONG UNITS OF SERVICE.
8025	SURS INITIATED A FULL OFFSET DUE TO WRONG PATIENT LIABILITY AMOUNT.
8026	SURS INITIATED A FULL OFFSET DUE TO PAYMENT IN FULL FROM ANOTHER INSURANCE.
8027	SURS INITIATED A FULL OFFSET DUE TO PAYMENT IN FULL FROM MEDICARE.
8028	SURS INITIATED A FULL OFFSET DUE TO WRONG DATE(S) OF SERVICE.
8030	PROVIDER REQUESTED OFFSET DUE TO BILLING ERROR.
8031	PROVIDER REQUESTED OFFSET DUE TO OTHER INSURANCE.
8032	PROVIDER REQUESTED OFFSET DUE MEDICARE.
8033	PROVIDER REQUESTED OFFSET DUE TO PATIENT LIABILITY.
8034	PROVIDER REQUESTED OFFSET DUE TO SPENDDOWN.
8035	PROVIDER REQUESTED OFFSET DUE TO AUTO LIABILITY.
8036	PROVIDER REQUESTED OFFSET DUE TO WORKERS COMP
8037	PROVIDER REQUESTED CLAIM VOID DUE TO BILLING ERROR.
8038	PROVIDER REQUESTED OFFSET DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR
8039	YOUR ADJUSTMENT REQUEST HAS RESULTED IN THE DENIAL AND RECOUPMENT OF THE CLAIM.PLEASE RESUBMIT YOUR ORIGINAL CLAIM, WITH CORRECTIONS, FOR PROCESSING.
8040	PROVIDER INITIATED INTERNET ADJUSTMENT
8041	ADJUSTMENT REQUEST DENIED. PLEASE CORRECT ERROR AND SUBMIT ANOTHER ADJUSTMENT-OR-SUBMIT ADJUSTMENT TO THE EDS ADJUSTMENT UNIT.
8042	SAVE FOR FUTURE USE.
8043	SAVE FOR FUTURE USE.
8044	SAVE FOR FUTURE USE.
8045	SAVE FOR FUTURE USE.
8046	SAVE FOR FUTURE USE.
8047	SAVE FOR FUTURE USE.
8048	SAVE FOR FUTURE USE.
8049	SAVE FOR FUTURE USE.
8050	EXPENDITURE WARRANT VOID
8051	SAVE FOR FUTURE USE.
8052	SAVE FOR FUTURE USE.
8053	SAVE FOR FUTURE USE.
8054	SAVE FOR FUTURE USE.
8055	SAVE FOR FUTURE USE.
8056	SAVE FOR FUTURE USE.
8057	SAVE FOR FUTURE USE.
8058	SAVE FOR FUTURE USE.
8059	PROVIDER SENT A FULL REFUND DUE TO COST SETTLEMENT (REQ FYE)
8060	PROVIDER SENT REFUND DUE TO BILLING ERROR.
8061	PROVIDER SENT REFUND DUE TO CLAIMS PROCESSING ERROR.
8062	PROVIDER SENT REFUND DUE TO DUPLICATE PAYMENT.
8063	PROVIDER SENT REFUND DUE TO MEMBER/RELATIVE PAID.
8064	PROVIDER SENT REFUND DUE TO MEDICARE PAID,
8065	PROVIDER SENT REFUND DUE TO CASUALTY INSURANCE PAID.
8066	PROVIDER SENT REFUND DUE TO HEALTH INSURANCE PAID.
8067	PROVIDER SENT REFUND DUE TO SURS REVIEW.
8068	PROVIDER SENT REFUND PAYMENT DUE TO SURS REVIEW.
8069	PROVIDER SENT REFUND DUE TO PAID WRONG VENDOR.
8070	PROVIDER SENT REFUND DUE TO MEDICAID FRAUD.
8071	PROVIDER SENT REFUND DUE TO MEDICAID ABUSE.

8072	PROVIDER SENT REFUND DUE TO AUTO INSURANCE PAID.
8073	PROVIDER SENT REFUND DUE TO WORKERS COMPENSATION PAID.
8074	PROVIDER SENT REFUND FOR ICN NOT IN HISTORY.
8075	PROVIDER SENT REFUND DUE TO MISCELLANEOUS OR OTHER UNSPECIFIED ERROR.
8076	PRV REFUND - OTHER TPL REASON
8077	PRV REFUND - PSYCH CROSSOVER
8079	SAVE FOR FUTURE USE.
8080	SAVE FOR FUTURE USE.
8081	SAVE FOR FUTURE USE.
8082	NON-CLAIM SPECIFIC REFUND DUE TO BILLING ERROR.
8083	NON-CLAIM SPECIFIC REFUND DUE TO OTHER INSURANCE.
8084	NON-CLAIM SPECIFIC REFUND DUE TO SURS.
8085	NON-CLAIM SPECIFIC REFUND DUE TO MISC OR UNSPECIFIED ERROR.
8086	SAVE FOR FUTURE USE.
8087	SAVE FOR FUTURE USE.
8088	SAVE FOR FUTURE USE.
8101	SAVE FOR FUTURE USE.
8102	SAVE FOR FUTURE USE.
8103	SAVE FOR FUTURE USE.
8104	SAVE FOR FUTURE USE.
8105	SAVE FOR FUTURE USE.
8106	SAVE FOR FUTURE USE.
8107	SAVE FOR FUTURE USE.
8135	EDS INITIATED OFFSET DUE TO PROCESSING ERROR
8136	INITIATED ADJUSTMENT DUE TO REVERSAL OF PREVIOUS PROCESSING OF RECOUP/CASH RECEIPT
8141	SAVE FOR FUTURE USE.
8142	SAVE FOR FUTURE USE.
8143	SAVE FOR FUTURE USE.
8144	SAVE FOR FUTURE USE.
8145	SAVE FOR FUTURE USE.
8146	SAVE FOR FUTURE USE.
8147	SAVE FOR FUTURE USE.
8148	SUPPLEMENTAL CLAIM VOID DUE TO ENCOUNTER VOID RECEIVED.
8149	ADJUSTMENT DUE TO SUPPLEMENTAL CLAIM PROCESSING.
8166	EDS INITIATED ADDITIONAL PAYMENT DUE TO PROCESSING ERROR.
8167	INITIATED ADJUSTMENT DUE TO REVERSAL PROCESSING OF RECOUP/CASH REFUND.
8179	YOUR VOID TRANSACTION HAS BEEN PROCESSED
8180	MASS ADJUSTMENT - INPATIENT HOSPITAL RATE CHANGE.
8181	MASS ADJUSTMENT - OUTPATIENT HOSPITAL RATE CHANGE
8182	MASS ADJUSTMENT- INDIAN HOSPITAL RATE CHANGE.
8183	MASS ADJUSTMENT - RURAL HEALTH CLINIC RATE CHANGE.
8184	MASS ADJUSTMENT - PROCEDURE CODE RATE CHANGE
8185	MASS ADJUSTMENT - RETROACTIVE RATE CHANGE.
8186	MASS ADJUSTMENT PROVIDER BILLING ERROR (RATE CHANGE).
8187	OTHER REQUEST FOR MASS ADJUSTMENT
8188	VOID TRANSACTIONS - MASS ADJUSTMENT
8189	MASS ADJUSTMENT - VOID TRANSACTIONS - REFUND RECEIVED
8190	MASS ADJUSTMENT - VOID TRANSACTIONS - WARRANT CANCELLED
8191	MASS ADJUSTMENT - VOID TRANSACTIONS OTHER REQUEST
8192	CLAIM ADJUSTED PER LEWIN MODEL DRG RATES.
8199	SAVE FOR FUTURE USE.
8200	TPL PRIVATE HEALTH INSURANCE - CARRIER
8201	TPL PRIVATE HEALTH INSURANCE - PROVIDER
8202	TPL PRIVATE HEALTH INSURANCE - MEMBER
8203	AUTO LIABILITY - CARRIER
8204	AUTO LIABILITY - PROVIDER
8205	AUTO LIABILITY - MEMBER
8206	NON-AUTO LIABILITY - CARRIE
8207	NON-AUTO LIABILITY - PROVIDER
8208	NON-AUTO LIABILITY - MEMBER
8209	WORKER'S COMP - CARRIER
8210	WORKER'S COMP - PROVIDER
8211	WORKER'S COMP - MEMBER
8212	PROBATE'S ESTATE
8213	INCOME PENSION TRUST RECOVERIES
8214	VICTIM'S RESTITUTION
8215	ABSENT PARENTS
8216	TPL ERROR
8217	DUE TO MISCELLANEOUS OR UNSPECIFIED REASON
8220	SAVE FOR FUTURE USE * TEMPORARILY USE FOR VOIDS *
8221	SAVE FOR FUTURE USE.
8222	SAVE FOR FUTURE USE
8223	SAVE FOR FUTURE USE.
8224	SAVE FOR FUTURE USE.
8225	CAPITATION - DEATH OF MEMBER
8226	CAPITATION - MEMBER INCARCERATED
8227	CAPITATION - EPSDT CLAIM
8228	CAPITATION - MEMBER ENROLLED IN ERROR
8229	CAPITATION - FAMILY PLANNING
8230	ICN VOIDED DUE TO WARRANT RETURN.
8231	CAPITATION - DEMOGRAPHIC CHANGE
8232	CAPITATION - OTHER
8233	SAVE FOR FUTURE USE.
8234	SAVE FOR FUTURE USE.
8240	ADJUSTMENT GENERATED DUE TO SURS REVIEW
8241	ADJUSTMENT GENERATED DUE TO CHANGE IN PATIENT LIABILITY
8242	ADJUSTMENT GENERATED DUE TO RATE CHANGE
8244	PAYOUT PROCESSED DUE TO DISPROPORTIONATE SHARE
8245	POINT OF SALE
8246	POINT OF SALE REVERSAL
8299	ADJUSTMENT TO CROSSOVER PAID PRIOR TO AIM IMPLEMENTATION DATE. THIS CLAIM HAS BEEN MANUALLY PRICED USING THE MEDICARE COINSURANCE, DEDUCTIBLE, AND PSYCHE RED
8300	A PAYOUT HAS BEEN ESTABLISHED FOR THE PROVIDER. THE REIMBURSEMENT IS INCLUDED IN THE CHECKWRITE.
8301	A PAYOUT HAS BEEN ESTABLISHED FOR THE PROVIDER. THE REIMBURSEMENT HAS BEEN EXCLUDED FROM THE CHECKWRITE.
8302	A PAYOUT IS DUE TO THE PROVIDER AS A RESULT OF OVER REFUND. THE REIMBURSEMENT IS INCLUDED IN THE CHECKWRITE.
8303	A PAYOUT IS DUE TO THE PROVIDER AS A RESULT OF OVER PAYMENT. THE REIMBURSEMENTHAS BEEN EXCLUDED FROM THE CHECKWRITE.
8304	PAYOUT DUE TO ADVANCE. PAYMENT INCLUDED IN CHECKWRITE.

8305	PAYOUT DUE TO ADVANCE. PAYMENT EXCLUDED FROM CHECKWRITE.
8306	CHECK RECEIVED BY EDS FOR CLAIM ADJUSTMENT ON A PREVIOUSLY ADJUSTED CLAIM. AMOUNT OF REFUND BEING RETURNED TO PROVIDER.
8307	PAYOUT EXCLUDED FROM CHECKWRITE.
8308	PAYOUT DUE TO HOSPITAL SUPPLEMENTAL GME ADJUSTMENT
8309	PAYOUT DUE TO MANAGED CARE - RESIDENT PCP PAYMENT
8310	PAYOUT DUE TO MANAGED CARE - RESIDENT DELIVERY PAYMENT
8311	PAYOUT DUE TO MANAGED CARE - ABD RISK BASED PAYM
8312	PAYOUT DUE TO MANAGED CARE - SP/ABD QUARTERLY PAYMENT
8313	PAYOUT DUE TO MANAGED CARE - EPSDT BONUS PAYMENT
8314	PAYOUT DUE TO MANAGED CARE - CUSTODY INDICATOR ERROR
8315	PAYOUT DUE TO MANAGED CARE - ENROLLMENT ERROR
8316	PAYOUT DUE TO MANAGED CARE - OTHER
8317	PAYOUT DUE TO MEDICAL AUTHORIZATION UNIT REVIEW -CCU
8318	PAYOUT DUE TO LONG TERM CARE FACILITY CERTIFICATION DATE ERROR
8319	PAYOUT DUE TO LONG TERM CARE FACILITY CLAIM PROCESSING ERROR
8320	PAYOUT DUE TO PATIENT LIABILITY ERROR
8321	PAYOUT DUE TO PATIENT SPENDDOWN ERROR
8322	PAYOUT DUE TO ENHANCED RATE-OUT OF STATE RTC SERVICES
8323	PAYOUT DUE TO NON-EMERGENCY TRANSPORTATION
8325	PAYOUT DUE TO GAS SURCHARGE.
8326	PAYOUT DUE TO CORRECTION TO ACCOUNTS RECEIVABLE PROCESSED.
8327	PAYOUT DUE TO DHS/DDSD SUPPORTED LIVING PROGRAM AUDIT.
8328	PAYOUT DUE TO DHS/DDSD AUDIT
8329	PAYOUT PROCESSED FROM STATE ONLY FUNDS
8330	PAYOUT DUE TO ELIGIBILITY NOT ON FILE.
8331	PAYOUT DUE TO CLAIM TOO OLD TO PROCESS
8332	PAYOUT DUE TO MISCELLANEOUS OR UNSPECIFIED REASON.
8336	RETROACTIVE INTEREST PAYMENT
8352	CAPITATION WARRANT VOID
8399	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED.
8400	ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED . THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS.
8401	DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS.
8402	DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8403	DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8404	DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8405	DUE TO A LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8406	DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8407	RELEASE OF LIEN RECEIVED BY LIEN HOLDER
8408	DECREASE TO ORIGINAL LIEN AMOUNT.
8409	INCREASE TO ORIGINAL LIEN AMOUNT
8410	SAVE FOR FUTURE USE
8411	SAVE FOR FUTURE USE
8412	SAVE FOR FUTURE USE
8413	SAVE FOR FUTURE USE
8414	SAVE FOR FUTURE USE
8415	SAVE FOR FUTURE USE .
8419	SAVE FOR FUTURE USE
8420	AS THE RESULT OF AN AUDIT DIVISION REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8421	AS THE RESULT OF CLAIMS PROCESSING ERROR, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8422	AS THE RESULT OF A COST SETTLEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8423	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/DDSD AUDIT.
8424	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/CHILD WELFARE.
8425	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO JUVENILE JUSTICE.
8426	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DISPROPORTIONATE SHARE ADJUSTMENT.
8427	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DRUG REBATE..
8428	AS THE RESULT OF A FINANCIAL MANAGEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8429	AS THE RESULT OF A LEGAL SETTLEMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8430	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO LONG TERM CARE FACILITY CLAIM PROCESSING ERROR.
8431	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MANAGED CARE ADJUSTMENTS.
8432	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MEDICAID FRAUD.
8433	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MEDICAL DIVISION REVIEW.
8434	AS THE RESULT OF AN OFMQ REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8435	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PATIENT LIABILITY ERROR.
8436	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PATIENT SPENDDOWN ERROR.
8437	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PHARMACY DIVISION REVIEW.
8438	AS THE RESULT OF A SURS AUDIT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8439	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO THIRD PARTY LIABILITY.
8440	SAVE FOR FUTURE USE.
8441	CLAIM GENERATED DUE TO ICN ON AR ROLLUP AND PARTIAL RECOUPMENT/REFUND APPLIED TO OFFSET.
8442	SAVE FOR FUTURE USE.
8443	SAVE FOR FUTURE USE.
8444	SAVE FOR FUTURE USE.
8445	SAVE FOR FUTURE USE.
8446	SAVE FOR FUTURE USE.
8447	SAVE FOR FUTURE USE.
8448	SAVE FOR FUTURE USE.
8449	SAVE FOR FUTURE USE.
8450	THIS ACCOUNT RECEIVABLE HAS BEEN CREATED DUE TO CAPITATION PROCESSING.
8451	DUE TO AN ADJUSTMENT SUBMITTED BY PROVIDER FOR A CLAIM TOO OLD TO PROCESS, AN ACCOUNT RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR P
8452	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR.
8453	THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG AMOUNT. WE HAVE MADE CORRECTION AND INCREASED THIS ACCOUNTS RECEIVABLE.
8454	THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG AMOUNT. WE HAVE MADE CORRECTION AND DECREASED THIS ACCOUNTS RECEIVABLE.
8455	THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG PROVIDER. WE HAVE CORRECTED THE ACTION AND DECREASED THIS ACCOUNTS RECEIVABLE.
8456	CLAIM DUE TO CASH RECEIPT APPLIED TO AND DECREASED AN ACCTS RECEIVABLE.
8457	AN OVER REFUND HAS BEEN APPLIED AND DECREASED THIS ACCOUNTS RECEIVABLE
8458	A STOP PAYMENT CHECK WAS APPLIED AND DECREASED THIS ACCOUNTS RECEIVABLE.
8459	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO FINANCIAL DIVISION REVIEW.
8460	THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO FINANCIAL DIVISION REVIEW
8461	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO AUDIT DIVISION REVIEW.
8462	THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO AUDIT DIVISION REVIEW.
8463	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO SURS REVIEW.
8464	THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO SURS REVIEW.
8465	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO INTEREST BEING APPLIED.
8466	THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED BY A MISCELLANEOUS ACTION
8467	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED BY A MISCELLANEOUS ACTION.
8468	THIS ACCOUNTS RECEIVABLE HAS BEEN WRITTEN OFF.

8469	THIS ACCOUNTS RECEIVABLE WAS DECREASED BY A CLAIM OFFSET
8470	CLAIM DUE TO ACCOUNT RECEIVABLE AND INCREASED DUE TO PRV UNDERPAYMENT.
8500	PAYMENT WITHHELD DUE TO A LIEN THAT WAS ESTABLISHED FROM A COURT ORDER.
8501	PAYMENT WITHHELD DUE TO AN IRS LEVY ESTABLISHED.
8502	PAYMENT WITHHELD DUE TO A LIEN THAT WAS ESTABLISHED FROM OTHER LEGAL ENTITY.
8510	CYCLE ACTIVITY
8511	DECREASE TO ORIGINAL LIEN AMOUNT RECEIVED BY LIEN HOLDER.
8512	DECREASE TO ORIGINAL LIEN AMOUNT DUE TO PAYMENT RECEIVED.
8513	INCREASE TO ORIGINAL LIEN AMOUNT RECEIVED BY LIEN HOLDER.
8514	RELEASE OF LIEN RECEIVED BY LIEN HOLDER.
8515	YOUR VOID TRANSACTION HAS BEEN PROCESSED.
8600	ZERO CREDIT BALANCE
8601	PROV REFUND-HEALTH INSUR PAID
8602	PROV REFUND-RECIPIENT/REL PAID
8603	PROV REFUND-CASUALTY INSU PAID
8604	PROV REFUND-PAID WRONG VENDER
8605	PROV REFUND-APPLY TO ACCT RECV
8606	PROV REFUND-PROCESSING ERROR
8607	PROV REFUND-BILLING ERROR
8608	PROV REFUND-FRAUD
8609	PROV REFUND-ABUSE
8610	PROV REFUND-DUPLICATE PAYMENT
8611	PROV REFUND-COST SETTLEMENT
8612	PROV REFUND-OTHER/UNKNOWN
8613	ACCT RECEIVABLE - FRAUD
8614	ACCT RECEIVABLE - ABUSE
8615	ACCT RECEIVABLE - TPL
8616	ACCT RECV - COST SETTLEMENT
8617	ACCT RECEIVABLE-KYMMIS REQUEST
8618	RECOUPMENT - WARRANT REFUND
8619	ACT RECEIVABLE-SURS OTHER
8620	ACCT RECEIVABLE - DUP PAYT
8621	RECOUPMENT - FRAUD
8622	CIVIL MONEY PENALTY
8623	RECOUPMENT-HEALTH INSUR TPL
8624	RECOUPMENT-CASUALTY INSUR TPL
8625	RECOUPMENT-RECIPIENT PAID TPL
8626	RECOUPMENT - PROCESSING ERROR
8627	RECOUPMENT - BILLING ERROR
8628	RECOUPMENT - COST SETTLEMENT
8629	RECOUPMENT - DUPLICATE PAYMENT
8630	RECOUPMENT - PAID WRONG VENDOR
8631	RECOUPMENT - SURS
8632	PAYOUT-ADVANCE TO BE RECOUPED
8633	PAYOUT - ERROR ON REFUND
8634	PAYOUT - RTP
8635	PAYOUT - COST SETTLEMENT
8636	PAYOUT - OTHER
8637	PAYOUT - MEDICARE PAID TPL
8638	RECOUPMENT - MEDICARE PAID TPL
8639	RECOUPMENT - DEDCO
8640	PROVIDER REFUND-OTHER TPL RSN
8641	ACCT RECV - PATIENT ASSESSMENT
8642	ACCT RECV - ORTHODONTIC FEE
8643	ACCT RECEIVABLE - KENPAC
8644	PARTICIP REQUIREMENTS FAILURE
8645	ACCT RECEIVABLE - OTHER
8646	AR CDR HOSP AUDIT
8647	ACT REC-DEMAND PAYMT UPDT 1099
8648	ACT REC-DEMAND PAYMT NO 1099
8649	PCG - PART A RECOVERIES
8650	RECOUPMENT - COLD CHECK
8651	PROG INTRE POST PAY REV CONT A
8652	PROG INTRE POST PAY REV CONT B
8653	CLAIM CREDIT BALANCE
8654	RECOUPMENT-OTHER ST BRANCH
8655	RECOUPMENT - OTHER
8656	RECOUPMENT - TPL CONTRACTOR
8657	ACCT RECV - ADVANCE PAYMENT
8658	RECOUPMENT - ADVANCE PAYMENT
8659	NON CLAIM RELATED OVERAGE
8660	PROVIDER INITIATED ADJUSTMENT
8661	PROVIDER INITIATED CLM CREDIT
8662	CLM CR-PAID MEDICAID VS XOVER
8663	CLM CR-PAID XOVER VS MEDICAID
8664	CLM CR-PAID INPATIENT VS OUTP
8665	CLM CR-PAID OUTPATIENT VS INP
8666	CLM CREDIT-PROV NUMBER CHANGED
8667	TPL CLM NOT FOUND ON HISTORY
8668	FIN CLM NOT FOUND ON HISTORY
8669	FINANCIAL WITHHOLD PAYMENT
8670	KENPAC INCENTIVE PAYMENT
8671	ENC DATA UNACCEPTABLE
8672	AR OVERAGE LT 99
8673	NO MEDICAID/PARTNERSHIP ENROLL
8674	PROV DATA UNACCEPTABLE
8675	PCP DATA UNACCEPTABLE
8676	WITHOLD OTHER
8677	RECIP INTENTIONAL PGM VIOLATE
8678	CAP ADJUSTMENT OTHER
8679	RECIPIENT NOT ELIGIBLE FOR DOS
8680	ADHOC ADJUSTMENT REQUEST
8681	ADJ DUE TO SYSTEM CORRECTIONS
8682	CONVERTED ADJUSTMENT
8683	MASS ADJ WARR REFUND
8684	DMS MASS ADJ REQUEST

8685	MASS ADJ SURS REQUEST
8686	THIRD PARTY PAID - TPL
8687	CLAIM ADJUSTMENT - TPL
8688	BEGINNING DUMMY RECOUPMENT BAL
8689	ENDING DUMMY RECOUPMENT BAL
8690	RETRO RATE MASS ADJ
8691	BEGINNING CREDIT BALANCE
8692	ENDING CREDIT BALANCE
8693	BEGINNING DUMMY CREDIT BALANCE
8694	ENDING DUMMY CREDIT BALANCE
8695	BEGINNING RECOUPMENT BALANCE
8696	ENDING RECOUPMENT BALANCE
8697	BEGIN DUMMY REC BAL
8698	END DUMMY RECOUP BALANCE
8699	UNIT DOSE RETURN DRUG ADJ
8700	PCG 2 PART A RECOVERIES
8701	PCG 2 PART B RECOVERIES
8702	PCG 2 AR CDR HOSP
8703	CONVERTED CLAIM CREDIT BALANCE
8704	DRG RETRO REVIEW
8705	DECEASED RECIPIENT RECOUPMENTS
8706	IMPACT PLUS
8707	INTEREST RECEIVED
8708	PROG INTRE POST PAY REV CONT C
8709	ON DEMAND RECOUPMENT REFUND
8710	RECOUP PAYOUT
8711	RECOUPMENT REFUND
8712	STATE SHARE
8713	KYMMIS MEDICARE PART A RECOUP
8714	REG. PSYCH. CROSSOVER REFUND
8998	CLAIM BEING REVIEWED
8999	ADJUSTMENT TO CROSSOVER PAID PRIOR TO 1/1/95. THIS CLAIM HAS BEEN MANUALLY PRICED USING THE MEDICARE COINSURANCE, DEDUCTIBLE, AND PSYCHE REDUCTION AMOUNTS.
9000	THE SUBMITTED CHARGE EXCEEDS THE ALLOWED CHARGE. CLAIM PAID AT THE KY MEDICAIDALLOWED AMOUNT.
9001	REIMBURSEMENT REDUCED BY THE MEMBER'S CO-PAYMENT AMOUNT.
9002	ACTUAL ITEMIZED COST INVOICE MUST BE SUBMITTED WHEN BILLING THIS PROCEDURE CODE. PLEASE RESUBMIT WITH AN INVOICE.
9003	NO PAYMENT MADE-TPL/SPENDDOWN IS MORE THAN THE ALLOWED AMOUNT.
9004	PERSONAL RESOURCE AMOUNT DEDUCTED FROM THE ALLOWED AMOUNT.
9005	COMPLETE PROCEDURE NOT PAYABLE WHEN THE TECHNICAL AND PROFESSIONAL COMPONENTS HAVE BEEN PAID FOR THE SAME PROCEDURES ON THE SAME DATE OF SERVICE.
9006	THIS ITEM SHOULD NOT BE BILLED WITH THIS PROCEDURE CODE.
9007	A PROCEDURE CODE IS REQUIRED WHEN BILLING THIS REVENUE CODE. PLEASE RESUBMIT WITH A PROCEDURE CODE.
9008	LINE ITEM SUBMITTED WITH UNCLEAR ITEMIZATION. PLEASE RESUBMIT WITH APPROPRIATEAND/OR ADDITIONAL INFORMATION.
9009	SERVICE DENIED. REIMBURSEMENT FOR INPATIENT HOSPITAL CARE LIMITED TO ONCE PER DAY.
9010	SERVICE IS NON-COVERED UNDER THE OKLAHOMA HEALTH COVERAGE PROGRAM
9011	SUPPORTING DOCUMENTATION IS NEEDED FOR THE MODIFIER(S) SUBMITTED ON THIS CLAIM.
9012	WRONG CLAIM FORM SUBMITTED. PLEASE RESUBMIT ON A UB92 CLAIM FORM.
9013	CLAIM UNDER REVIEW - FOR INTERNAL USE ONLY
9015	MCO CANNOT ADJUST OR VOID A FEE-FOR-SERVICE CLAIMS AND VICE VERSA.
9016	THE OVERHEAD OCCURRENCE DATES BILLED ON THE CLAIM DO NOT AGREE WITH THE DATES OF SERVICE BILLED ON THE CLAIM DETAILS. THE OVERHEAD FEE WAS APPLIED TO ALL DET
9017	SEPARATE REIMBURSEMENT IS NOT AVAILABLE FOR COMPONENT PROCEDURES WHEN GLOBAL PROCEDURE HAS BEEN PAID.
9018	837 ADJUSTMENT ERROR -- MEMBER MEDICAID ID NOT PRESENT
9019	837 ADJUSTMENT ERROR -- CROSSOVER PROVIDER ID NOT PRESENT
9020	837 ADJUSTMENT ERROR -- PROVIDER ID NOT PRESENT
9021	837 ADJUSTMENT ERROR -- UNABLE TO FIND ORIGINAL ICN
9022	YOU CANNOT ADJUST OR VOID A THRESHOLDED ENCOUNTER.
9023	837 ADJUSTMENT ERROR -- RECIPIENT NOT FOUND
9024	837 ADJUSTMENT ERROR -- PROVIDER NOT FOUND
9025	837 ADJUSTMENT ERROR -- MATCHING CLAIM NOT FOUND
9026	837 ADJUSTMENT ERROR -- CLAIM HAS ALREADY BEEN ADJUSTED
9027	837 ADJUSTMENT ERROR -- CLAIM IS SCHEDULED TO BE ADJUSTED BY ANOTHER PROCESS
9028	837 ADJ ERROR- PROV/TAXNMY/ZIP NOT MATCHING ORGIN
9029	837 ADJ-CURRENT CLAIM TYPE NOT MATCHING ORIGN
9030	CRITICAL CARE/NEONATAL INTENSIVE CARE VISIT CODES NOT PAYABLE WHEN THE AMOUNT PREVIOUSLY PAID FOR PROCEDURES INCLUDED IN THE VISIT CODE EQUAL THE REIMBURSEMEN
9031	GLOBAL IMMUNIZATION PROCEDURE CODES NOT PAYABLE WHEN THE AMOUNT PREVIOUSLY REIMBURSED FOR THE RELATED COMPONENT IMMUNIZATION PROCEDURE(S) EQUALS THE REIMBURSE
9032	CLAIM DENIED. EDI ADJUSTMENT NOT ALLOWED FOR ELECTRONIC CLAIM WITH ATTACHMENTS.
9036	ORAL SURGERY NOT PAYABLE WHEN AMOUNT PAID FOR APICOECTOMY ON SAME DATE OF SERVICE EXCEEDS OKLAHOMA HEALTH COVERAGE PROGRAM ALLOWABLE FOR THE PROCEDURE BILLED.
9040	REIMBURSEMENT IS FOR THE VFC (VACCINE FOR CHILDRENS PROGRAM) VACCINE ADMINISTR ATION FEE ONLY
9075	CLAIM DENIED. STERILIZATION CONSENT FORM INCOMPLETE OR IMPROPERLY COMPLETED.A STERILIZATION CHECKLIST AND YOUR CLAIM ARE BEING SENT TO YOU WITH THE ERRORS/OM
9080	NON COVERED CHARGES
9090	XOVER W/O MEDICARE SEGMENT FOR REVIEW
9107	FULL SERIES SPINAL X-RAY NOT PAYABLE WHEN THE AMOUNT PAID FOR COMPONENTS OF THESPINAL SERIES X-RAYS WITHIN THE SAME CALENDAR YEAR EQUAL THE REIMBURSMENT AMOU
9111	INTERNAL PROCESSING ERROR - CONTACT SE MANAGER
9122	NO PRICING METHOD ASSIGNED OR UNKNOWN
9175	CLAIM DENIED. MEMBER'S SIGNATURE AND DATE OF SIGNATURE IN THE MEMBER'S SECTIONOF THE CONSENT FORM ARE IN ERROR AND ARE NON CORRECTABLE FIELDS.
9256	TREND EVENT MONITOR IS REIMBURSABLE TO A MAXIMUM OF $850.00 PER MONTH, BUT IS NOT PAYABLE WHEN RELATED COMPONENTS HAVE BEEN REIMBURSED FOR THE MAXIMUM AMOUNT.
9257	MAXIMUM REIMBURSEMENT FOR OXIMETRY IS $280.00 PER 30 DAYS. MAXIMUM REIMBURSEMENT HAS BEEN PAID.
9260	PARENTERAL/ENTERAL FEEDING KIT PAYABLE AT A REDUCED AMOUNT WHEN RELATED SUPPLIES HAVE BEEN PAID WITHIN THE SAME THIRTY DAY (30) TIME PERIOD. REIMBURSEMENT REF
9300	MASS ADJUSTMENT SUSPENDED FOR REVIEW
9302	INVALID BENEFIT PLAN ON CLAIM
9303	UNABLE TO ASSIGN PROVIDER CONTRACT
9304	DUE TO CONDITIONS NOT PRESENT ON ADMISSION, SOME DIAGNOSIS CODES WERE NOT CONSIDERED IN THE DRG ASSIGNMENT PROCESS. THIS MAY HAVE AFFECTED YOUR PAYMENT.
9400	THE NUMBER OF SERVICES EXCEED MEDICAL POLICY GUIDELINES. PRIOR AUTHORIZATION REQUIRED FOR ADDITIONAL SERVICES.
9500	SUPPLEMENTAL CLAIM CREATED DUE TO MCO ENCOUNTER RECEIVED.
9501	SUPPLEMENTAL CLAIM CREATED DUE TO MCO ENCOUNTER RECEIVED. NO SUPPLEMENTAL PAYMENT DUE.
9502	PAID AMOUNT OF A FEE-FOR-SERVICE MY REWARDS CLAIM HAS BEEN DEDUCTED FROM YOUR SUPPLEMENTAL CLAIM PAYMENT.
9600	REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF LENSES PER YEAR FOR MEMBERS 18 YEARS OF AGE AND UNDER. PROVIDERS MUST SUBMIT XP-MODIFIER WHEN MEMBERS
9601	REIMBURSEMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF FRAMES PER YEAR FOR MEMBERS 18 YEARS OF AGE AND UNDER. PROVIDERS MUST SUBMIT XP-MODIFIER WHEN MEMBERS
9603	THE DATE OF SERVICE ON THIS CLAIM MATCHES THE MEMBER'S SPENDOWN MET DATE FORTHE MONTH. AN 8A FORM IS REQUIRED. POS PROVIDERS MUST SUBMIT THIS CLAIM ON P APE
9604	REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF LENSES EVERY (2) TWO YEARS FOR MEMBERS 19 YEARS OF AGE OR OLDER. PROVIDERS MUST SUBMIT XP-MODIFIER WHE
9605	HOSPITAL LEAVE DAYS ARE LIMITED TO 15 PER HOSPITALIZATION. THE PATIENT SHOULD BE DISCHARGED AND READMITTED FOLLOWING THE HOSPITAL STAY.
9634	COMPLETE PROCEDURE NOT PAYABLE WHEN THE TECHNICAL AND PROFESSIONAL COMPONENTS HAVE BEEN PAID FOR THE SAME PROCEDURE ON THE SAME DATE OF SERVICE.
9651	SURGERIES ON THE SAME DATE OF SERVICE, IN THE EXCESS OF TWO, ARE PAID AT 25 PERCENT OF THE OKLAHOMA HEALTH COVERAGE PROGRAM'S ALLOWED.
9660	THIS SERVICE IS NOT PAYABLE, MEMBER IS QMB ALSO AND SPENDDOWN HAS NOT BEEN MET FOR THE MONTH. ONLY REIMBURSEMENT FOR COINSURANCE AND DEDUCTIBLE ON CLAIMS CRO
9661	POS REVERSAL PROCESSING DEFERRED DURING FINANCIAL CYCLE
9662	CLAIM DENIED. ATTACHMENT NOT RECEIVED.
9663	ATTACHMENT BEING SENT BY PROVIDER FOR AN ELECTRONIC CLAIM.
9664	THE NUMBER OF QUADRANTS BILLED ON THE CLAIM IS NOT EQUAL TO THE NUMBER OF UNITS BILLED.

9665	TOOTH NUMBERS CANNOT BE BILLED WITH A PROCEDURE THAT REQUIRES QUADRANTS.
9666	THE ATTACHMENT TYPE IS NOT VALID.
9700	THE DISPENSING FEE HAS BEEN REDUCED TO THE ALLOWABLE
9701	THE QUANTITY DISPENSED HAS BEEN REDUCED TO THE ALLOWABLE QUANTITY
9702	DOLLARS ADJUSTED TO PARAMETER LIMIT
9703	QTY ADJUSTED TO PARAMETER LIMIT
9704	COVERED DAYS REDUCED TO ALLOWABLE
9705	VISITS REDUCED TO AUTHORIZED
9706	PA CHARGE REDUCED TO AUTHORIZED
9707	PA UNITS REDUCED TO AUTHORIZED
9708	THER DAYS REDUCED TO AUTHORIZED
9709	MAX 14 CONSECUTIVE THER DAYS ALLOWED
9710	HOSP LEAVE DAYS REDUCED TO AUTHORIZED
9800	CUTBACK DUE TO HMO PAYMENT
9878	THE SUM OF THE OTHER PAYER DETAIL PAID AMOUNT PLUS THE OTHER PAYER CLAIM DETAILADJUSTMENT AMOUNTS MUST EQUAL THE CLAIM DETAIL BILLED AMOUNT.
9900	REIMBURSEMENT LIMITED TO ONE SET OF LENSES PER YEAR FOR MEMBERS 18 YEARS OF AGE AND YOUNGER UNLESS REPAIRS OR REPLACEMENTS ARE DUE TO EXTENUATING CIRCUMSTANCE
9901	REIMBURSEMENT LIMITED TO ONE SET OF FRAMES PER YEAR FOR MEMBERS 18 YEARS OF AGE AND YOUNGER UNLESS REPAIRS OR REPLACEMENT IS DUE TO EXTENUATING CIRCUMSTANCES
9902	PROCEDURE CODE GROUP NOT FOUND
9903	REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF FRAMES EVERY (2) YEARS FOR MEMBERS 19 YEARS OF AGE OR OLDER. PROVIDERS MUST SUBMIT XP-MODIFIER WHENMEM
9904	SERVICE DENIED. REIMBURSEMENT LIMITED TO ONE SET OF LENSES EVERY TWO YEARS FORMEMBERS 19 YEARS OR OLDER UNLESS REPAIRS OR REPLACEMENT IS DUE TO EXTENUATI NG
9905	SERVICE DENIED-MEDICAL NECESSITY DOCUMENTATION MUST BE PROVIDED WITH CLAIM STATING REASON FOR MEDICAL NECESSITY.
9906	PRICING ADJUSTMENT - MEDICARE PART B PRICING APPLIED
9907	TPL AMOUNT APPLIED
9908	PRICING ADJUSTMENT - PHARMACY PRICING APPLIED
9909	PRICING ADJUSTMENT - 50% OF AMOUNT BILLED APPLIED
9910	PHARMACY DISPENSING FEE APPLIED
9911	PRICING ADJUSTMENT - LONG TERM CARE PRICING APPLIED
9912	PRICING ADJUSTMENT - AMBULATORY SURGERY PRICING APPLIED
9913	PRICING ADJUSTMENT - OUTPATIENT EPOGEN PRICING APPLIED
9914	PRICING ADJUSTMENT - REVENUE CODE RATE PRICING APPLIED
9915	PRICING ADJUSTMENT - MEDICARE PART A PRICING APPLIED
9916	PRICING ADJUSTMENT - UCC RATE PRICING APPLIED
9917	PRICING ADJUSTMENT - PREVAILING FEE PRICING APPLIED
9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
9919	PRICING ADJUSTMENT - PROVIDER LOC PRICING APPLIED
9920	PRICING ADJUSTMENT - RBRVS PRICING APPLIED
9921	PRICING ADJUSTMENT - PA PRICING APPLIED
9922	SPENDDOWN DEDUCTIBLE/PATIENT LIABILITY APPLIED
9923	SPENDDOWN PATIENT LIABILITY APPLIED
9924	CLAIM HAS FICA AMOUNT
9925	CLAIM HAS RECOUPMENT AMOUNT
9926	CLAIM HAS CUTBACK AMOUNT
9927	SYSTEM FUND CODE REASSIGNMENT
9928	PRICING ADJUSTMENT - COVID VACCINATION ADMINISTRATION 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 BALANCE TO THE CLAIM LEVEL PAYMENT AMOUNT.
9980	PROVIDER TYPE SPECIALTY GROUP NOT FOUND
9981	DIAGNOSIS CODE GROUP NOT FOUND
9983	ICD PROCEDURE CODE GROUP NOT FOUND
9984	MODIFIER CODE GROUP NOT FOUND
9985	NDC DRUG TYPE GROUP NOT FOUND
9986	REVENUE CODE GROUP NOT FOUND
9987	DRG CODE GROUP NOT FOUND
9988	TYPE OF BILL GROUP NOT FOUND
9990	BENEFIT PLAN TYPE GROUP NOT FOUND
9991	REFUND AMOUNT LESS THAN ADJUSTED AMOUNT
9992	REFUND AMOUNT GREATER THAN ADJUSTED AMOUNT
9995	ADJUSTMENT DETAIL MANUALLY DENIED
9996	PAYMENT REDUCED DUE TO PATIENT LIABILITY DEDUCTION.
9997	PERSONAL RESOURCES DEDUCTED FROM THE CLAIM ARE A RESULT OF PREVIOUS RESOURCES COLLECTED FOR THE MEMBER IN THE SAME MONTH.
9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT KENTUCKY HEALTH COVERAGE PROGRAM POLICIES.
9999	PROCESSED PER MEDICAID POLICY