

EOB	MEDICAID EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE DESCRIPTION		HIPAA REMARK CODE DESCRIPTION		HIPAA CLAIM STATUS CODE DESCRIPTION	
1	Fee adjusted to maximum allowable	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	65	Claim-line has been paid.
1	Fee adjusted to maximum allowable	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	483	Maximum coverage amount met or exceeded for benefit period
4	Provider number missing or invalid. Enter corrected provider number on the claim and submit as a new claim	125	Submission-billing error(s)	N77	Missing-incomplete-invalid designated provider number.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
4	Provider number missing or invalid. Enter corrected provider number on the claim and submit as a new claim	125	Submission-billing error(s)	N77	Missing-incomplete-invalid designated provider number.	132	Entitys Medicaid provider id. Note- This code requires use of an Entity Code.
6	Patient liability/deductible reduced payable amount	142	Monthly Medicaid patient liability amount.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	98	Charges applied to deductible.
8	Paid per medical consultant review	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N10	Claim-service adjusted based on the findings of a review organization-professional consult-manual adjudication-medical or dental advisor.	65	Claim-line has been paid.

13	Mapped provider ID is not eligible on service date	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if presentNote- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present		No Mapping Required	91	Entity not eligible-not approved for dates of service.
13	Mapped provider ID is not eligible on service date	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present		No Mapping Required	562	Entitys National Provider Identifier (NPI)
14	Service denied per medical consultant review	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N10	Claim-service adjusted based on the findings of a review organization-professional consult-manual adjudication-medical or dental advisor.	297	Medical notes/report.
15	Payment reflects DME proration	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.
17	Adjustment request denied as beyond time limit	29	The time limit for filing has expired.	N10	Alert- You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents	294	Supporting documentation.
20	Claim being processed due to incorrect denial for EOB 525 on previous RA's	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.

21	Duplicate of claim/system	18	Exact duplicate claim-service	M86	Service denied because payment already made for same-similar procedure within set time frame.	54	Duplicate of a previously processed claim-line.
22	Duplicate of claim/system	18	Exact duplicate claim-service	M86	Service denied because payment already made for same-similar procedure within set time frame.	54	Duplicate of a previously processed claim-line.
24	Procedure code, procedure/modifier combination or revenue code is missing, invalid or invalid for this bill type. Correct and rebill denied detail as a new claim	125	Submission-billing error(s)		No Mapping Required	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
24	Procedure code, procedure/modifier combination or revenue code is missing, invalid or invalid for this bill type. Correct and rebill denied detail as a new claim	125	Submission-billing error(s)		No Mapping Required	228	Type of bill for UB claim.
24	Procedure code, procedure/modifier combination or revenue code is missing, invalid or invalid for this bill type. Correct and rebill denied detail as a new claim	125	Submission-billing error(s)		No Mapping Required	453	Procedure code modifier(s) for service(s) rendered.
25	Procedure denied for patient over 21 years old	6	The procedure-revenue code is inconsistent with the patients age. Note- Refer to the 835 Healthcare policy Identification Segment (loop 2110 Service Payment Information REF), if present Note- Refer to the 835 Healthcare policy Identification Segment (loop 2110 Service Payment Information REF), if present		No Mapping Required	475	Procedure code not valid for patient age.

27	Dianosis code missing or invalid. Verify and enter the correct diagnosis code and submit as a new claim	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing-incomplete-invalid diagnosis or condition.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
27	Dianosis code missing or invalid. Verify and enter the correct diagnosis code and submit as a new claim	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing-incomplete-invalid diagnosis or condition.	255	Diagnosis code.
27	Dianosis code missing or invalid. Verify and enter the correct diagnosis code and submit as a new claim	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing-incomplete-invalid diagnosis or condition.	477	Diagnosis code pointer is missing or invalid.
28	Payment include in dialysis charge	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	454	Procedure code for services rendered.
29	Medicare voucher does not match dates - Charges on claim or voucher not attached to claim - Rebill with correct voucher	148	Information from another provider was not provided or was insufficient-incomplete	N4	Missing-incomplete-invalid prior insurance carrier EOB.	286	Other payer's Explanation of Benefits/Payment information.
29	Medicare voucher does not match dates - Charges on claim or voucher not attached to claim - Rebill with correct voucher	148	Information from another provider was not provided or was insufficient-incomplete	N4	Missing-incomplete-invalid prior insurance carrier EOB.	492	Other Procedure Date.
30	Medicare paid in full	B13	Previously paid. Payment for this claim-service may have been provided in a previous payment.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	107	Processed according to contract-plan provisions. (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services).

30	Medicare paid in full	B13	Previously paid. Payment for this claim-service may have been provided in a previous payment.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	591	Medicare Paid at 100% Amount.
31	Partiall cutback for other insurance coverage	23	The impact of prior payer(s) adjudication including payments and-or adjustments		No Mapping Required	107	Processed according to contract-plan provisions.
32	Charge reduced by other insurance amount	23	The impact of prior payer(s) adjudication including payments and-or adjustments		No Mapping Required	107	Processed according to contract-plan provisions.
33	CAP service not allowed on or after January 31. 1992	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing-incomplete-invalid principal procedure code or date.	454	Procedure code for services rendered.
33	CAP service not allowed on or after January 31. 1992	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N303	Missing-incomplete-invalid principal procedure date.	454	Procedure code for services rendered.
37	Detail line not adjusted	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement		No Mapping Required	247	Line information.
37	Detail line not adjusted	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement		No Mapping Required	530	Claim Adjustment Indicator
39	Medicare denied, no coinsurance or deductible or Medicaid payment due	A1	Claim-Service denied	N8	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication	107	Processed according to contract-plan provisions.
39	Medicare denied, no coinsurance or deductible or Medicaid payment due	A1	Claim-Service denied	N8	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication	585	Denied Charge or Non-covered Charge

40	Admission date/date of service missing or invalid. Verify and enter correct DOS and submit as a new claim	125	Submission-billing error(s)	M52	Missing-incomplete-invalid from date(s) of service.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
40	Admission date/date of service missing or invalid. Verify and enter correct DOS and submit as a new claim	125	Submission-billing error(s)	N173	No qualifying hospital stay dates were provided for this episode of care.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
40	Admission date/date of service missing or invalid. Verify and enter correct DOS and submit as a new claim	125	Submission-billing error(s)	M52	Missing-incomplete-invalid from date(s) of service.	187	Date(s) of service.
40	Admission date/date of service missing or invalid. Verify and enter correct DOS and submit as a new claim	125	Submission-billing error(s)	N173	No qualifying hospital stay dates were provided for this episode of care.	187	Date(s) of service.
40	Admission date/date of service missing or invalid. Verify and enter correct DOS and submit as a new claim	125	Submission-billing error(s)	M52	Missing-incomplete-invalid from date(s) of service.	189	Facility admission date
40	Admission date/date of service missing or invalid. Verify and enter correct DOS and submit as a new claim	125	Submission-billing error(s)	N173	No qualifying hospital stay dates were provided for this episode of care.	189	Facility admission date
43	Acquisition of organs for transplant must be billed to the Transplant Hospital	109	Claim not covered by this payer-contractor. You must send the claim to the correct payer-contractor.		No Mapping Required	84	Service not authorized.
46	Patient liability/deductible exceeds allowed amount	142	Monthly Medicaid patient liability amount.	N58	Missing-incomplete-invalid patient liability amount.	483	Maximum coverage amount met or exceeded for benefit period.

51	Claim split to facilitate processing	125	Submission-billing error(s)	MA15	Alert- Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported	72	Claim contains split payment.
52	Office and/clinician visit includes payment for service	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	454	Procedure code for services rendered.
53	Payment included in daily care	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	454	Procedure code for services rendered.
55	Service included in the fee for visual aid	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	454	Procedure code for services rendered.
56	Office visit included in Fee for Service	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	454	Procedure code for services rendered.

58	Service dates prior to admission date. Verify admit date and DOS. Correct and rebill as a new claim	125	Submission-billing error(s)	MA31	Missing-incomplete-invalid beginning and ending dates of the period billed.	187	Date(s) of service.
58	Service dates prior to admission date. Verify admit date and DOS. Correct and rebill as a new claim	125	Submission-billing error(s)	MA31	Missing-incomplete-invalid beginning and ending dates of the period billed.	189	Facility admission date
59	Adjustments equal to or less than on dollar denied	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	MA22	Payment of less than \$1.00 suppressed.	104	Processed according to plan provisions.
62	Durable medical equipment guidelines not met	108	Rent-purchase guidelines were not met. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present		No Mapping Required	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
63	Correct assistan surgeons claim using TOS 08 in Field 24C of the CMS 1500 Claim Form and resubmit as a new claim	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	276	UB04-HCFA-1450-1500 claim form.
63	Correct assistant surgeons claim using TOS 08 in Field 24C of the CMS 1500 Claim Form and resubmit as a new claim	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	481	Claim submission format is invalid.

67	Claim payment recouped. File with Medicare Carrier using HIC# indicated on list mailed to your office. Be sure to use the appropriate claim form to bill Medicare	129	Prior processing information appears incorrect.	N36	Claim must meet primary payer's processing requirements before we can consider payment.	116	Claim submitted to incorrect payer.
68	Bill Medicare Part B Carrier	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	116	Claim submitted to incorrect payer.
72	Similar item previously rented or purchased	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	107	Processed according to contract-plan provisions.
72	Similar item previously rented or purchased	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	101	Claim was processed as adjustment to previous claim.
73	Claim paid copayment deducted	3	Co-payment Amount.		No Mapping Required	65	Claim-line has been paid.
76	Services not payable in advance	110	Billing date predates service date.	N301	Missing-incomplete-invalid procedure date(s).	510	Future date
78	Rebill as a new claim using the procedure code for subsequent care	125	Submission-billing error(s)	N56	Procedure code billed is not correct-valid for the service billed or the date of service billed.	454	Procedure code for services rendered.

84	Recipient is partially ineligible for service dates. Resubmit a new claim billing only eligible dates of service	239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims		No Mapping Required	187	Date(s) of service.
84	Recipient is partially ineligible for service dates. Resubmit a new claim billing only eligible dates of service	239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims		No Mapping Required	88	Entity not eligible for benefits for submitted dates of service.
85	Attending provider ID is missing, invalid, or unresolved. Verify attending provider ID and resubmit as a new claim or contact HP Provider Services if ID is correct	A1	Claim-Service denied	N253	Missing-incomplete-invalid attending provider primary identifier.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
85	Attending provider ID is missing, invalid, or unresolved. Verify attending provider ID and resubmit as a new claim or contact HP Provider Services if ID is correct	A1	Claim-Service denied	N253	Missing-incomplete-invalid attending provider primary identifier.	562	Entity's National Provider Identifier (NPI)
86	Adjustment of claim-system	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement		No Mapping Required	101	Claim was processed as adjustment to previous claim.
89	Prior approval number missing or invalid. Verify and/or add PA number and submit as a new claim	15	The authorization number is missing, invalid, or does not apply to the billed services or provider	N54	Claim information is inconsistent with pre-certified-authorized services.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
89	Prior approval number missing or invalid. Verify and/or add PA number and submit as a new claim	15	The authorization number is missing, invalid, or does not apply to the billed services or provider	N54	Claim information is inconsistent with pre-certified-authorized services.	84	Service not authorized.
91	Patient liab/deduct equal Medicare/Medicaid allowable	142	Monthly Medicaid patient liability amount.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	98	Charges applied to deductible.

93	Patient deceased per state eligibility file. If DOS and recipient MID are correct, submit claim to DMA, Claims Analysis Unit, see billing guidelines	13	The date of death precedes the date of service.	N1	Alert- You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents	88	Entity not eligible for benefits for submitted dates of service. Note- This code requires use of an Entity Code.
94	Resubmit claim indicating private insurance payment or applicable occurrence code. If documented insurance, denial required, submit with claim on provider inquiry form	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	171	Other insurance coverage information (health, liability, auto, etc.).
94	Resubmit claim indicating private insurance payment or applicable occurrence code. If documented insurance, denial required, submit with claim on provider inquiry form	22	This care may be covered by another payer per coordination of benefits.	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	171	Other insurance coverage information (health, liability, auto, etc.).
94	Resubmit claim indicating private insurance payment or applicable occurrence code. If documented insurance, denial required, submit with claim on provider inquiry form	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	286	Other payer's Explanation of Benefits/Payment information.
94	Resubmit claim indicating private insurance payment or applicable occurrence code. If documented insurance, denial required, submit with claim on provider inquiry form	22	This care may be covered by another payer per coordination of benefits.	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	286	Other payer's Explanation of Benefits/Payment information.
94	Resubmit claim indicating private insurance payment or applicable occurrence code. If documented insurance, denial required, submit with claim on provider inquiry form	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	286	Other payers Explanation of Benefits-payment information.

94	Resubmit claim indicating private insurance payment or applicable occurrence code. If documented insurance, denial required, submit with claim on provider inquiry form	22	This care may be covered by another payer per coordination of benefits.	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	286	Other payers Explanation of Benefits-payment information.
95	Medicare denied. Resubmit corrected claim or if Medicare override required, submit as inquiry with claim and Medicare EOMB attached	148	Information from another provider was not provided or was insufficient-incomplete	N82	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.	107	Processed according to contract-plan provisions
96	Patient liab/deduct applied to Medicare/Medicaid allowable	142	Monthly Medicaid patient liability amount.		No Mapping Required	98	Charges applied to deductible.
97	Paid in part/full by Medicare	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N360	Alert- Coordination of benefits has not been calculated when estimating benefits for this pre-determination. Submit payment information from the primary payer with the secondary claim.	107	Processed according to contract-plan provisions.
97	Paid in part/full by Medicare	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	286	Other payers Explanation of Benefits-payment information.
99	Paid as billed		Should not be cross walked for an 835 since there will not be a CAS segment.		Should not be cross walked for an 835 since there will not be a CAS segment.	65	Claim-line has been paid.
100	Payment will appear as financial transaction in the future	101	Predetermination: anticipated payment upon completion of services or claim adjudication.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	3	Claim has been adjudicated and is awaiting payment cycle.
101	Pending normal in-house processing	133	The disposition of this claim-service is pending further review.		No Mapping Required	3	Claim has been adjudicated and is awaiting payment cycle.
102	Pending in-house review	133	The disposition of this claim-service is pending further review.		No Mapping Required	3	Claim has been adjudicated and is awaiting payment cycle.

103	Recipient MID ineligible on service date/under review	31	Patient cannot be identified as our insured		No Mapping Required	88	Entity not eligible for benefits for submitted dates of service. Note- This code requires use of an Entity Code.
104	Recipient number not on state file - under review	31	Patient cannot be identified as our insured	MA27	Missing-incomplete-invalid entitlement number or name shown on the claim.	32	Subscriber and policy number-contract number not found.
105	Date of service is prior to date of birth. If date of service and recipient MID are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines	14	The date of birth follows the date of service.		No Mapping Required	158	Entitys date of birth.
105	Date of service is prior to date of birth. If date of service and recipient MID are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines	14	The date of birth follows the date of service.		No Mapping Required	88	Entity not eligible for benefits for submitted dates of service. Note- This code requires use of an Entity Code.
106	Recipient file problem under state review	31	Patient cannot be identified as our insured	N301	Patient ineligible for this service.	56	Awaiting eligibility determination.
108	Charges deleted for ineligible dates of service	238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period		No Mapping Required	178	Submitted charges.
108	Charges deleted for ineligible dates of service	238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period		No Mapping Required	187	Date(s) of service.
109	Accommodation/reimbursement rate adjusted to rate on file	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N153	Missing-incomplete-invalid room and board rate.	65	Claim-line has been paid.
109	Accommodation/reimbursement rate adjusted to rate on file	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	65	Claim-line has been paid.

109	Accommodation/reimbursement rate adjusted to rate on file	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N153	Missing-incomplete-invalid room and board rate.	631	Reimbursement Rate
109	Accommodation/reimbursement rate adjusted to rate on file	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	631	Reimbursement Rate
110	HPES changed claim due to recipient name/number mismatch	125	Submission-billing error(s)	MA27	Missing-incomplete-invalid entitlement number or name shown on the claim.	30	Subscriber and subscriber id mismatched.
111	Settlement amount added to claims payment due to state authorized payout	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement		No Mapping Required	104	Processed according to plan provisions.
112	Check amount reduced by recoupment amount	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.
113	Refund amount applied and 1099 credited for returned Medicaid payments	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement		No Mapping Required	104	Processed according to plan provisions.
114	Voided amount applied to 1099 liability	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement		No Mapping Required	104	Processed according to plan provisions.
115	Adj of claim pending in process-system	133	The disposition of this claim-service is pending further review.		No Mapping Required	3	Claim has been adjudicated and is awaiting payment cycle.
116	Reduced for deductible	1	Deductible Amount.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	98	Charges applied to deductible.
117	Denied for deductible	A1	Claim-Service denied	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	98	Charges applied to deductible.

118	Claim denied due to eligibility issue, resubmit claim to DMA Claims Analysis Unit	31	Patient cannot be identified as our insured	N142	The original claim was denied. Resubmit a new claim, not a replacement claim.	56	Awaiting eligibility determination.
119	Adjustment paid correctly per Medicaid guidelines	B13	Previously paid. Payment for this claim-service may have been provided in a previous payment.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.
119	Adjustment paid correctly per Medicaid guidelines	B13	Previously paid. Payment for this claim-service may have been provided in a previous payment.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	101	Claim was processed as adjustment to previous claim.
120	Recipient MID number missing. Enter MID and submit as a new claim	125	Submission-billing error(s)	MA61	Missing-incomplete-invalid social security number or health insurance claim number.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
120	Recipient MID number missing. Enter MID and submit as a new claim	125	Submission-billing error(s)	MA61	Missing-incomplete-invalid social security number or health insurance claim number.	478	Claim submitters identifier (patient account number) is missing.
121	Refile this claim and EOMB - system	A1	Claim-Service denied	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	481	Claim-submission format is invalid.
122	Dates of service before prior approval date. Verify DOS and PA number; correct and submit as a new claim	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	84	Service not authorized.
122	Dates of service before prior approval date. Verify DOS and PA number; correct and submit as a new claim	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	187	Date(s) of service.

123	Dates of service after prior approval DOS and PA number; correct and submit as new claim	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	84	Service not authorized.
123	Dates of service after prior approval DOS and PA number; correct and submit as new claim	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	187	Date(s) of service.
124	Exceeds state dental limitation	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum	259	Frequency of service.
125	Previously paid on claim - system	18	Exact duplicate claim-service	M86	Service denied because payment already made for same-similar procedure within set time frame.	259	Frequency of service.
127	Not in accordance with dental policy guidelines	B5	Coverage-program guidelines were not met or were exceeded.		No Mapping Required	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
130	Paid per dental consultant review	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N10	Claim-service adjusted based on the findings of a review organization-professional consult-manual adjudication-medical or dental advisor.	65	Claim-line has been paid.
134	Units/days and/or rate are not consistent with charges	125	Submission-billing error(s)	M53	Missing-incomplete-invalid days or units of service.	258	Days-units for procedure-revenue code.
134	Units/days and/or rate are not consistent with charges	125	Submission-billing error(s)	M54	Missing-incomplete-invalid total charges.	258	Days-units for procedure-revenue code.
136	Charge reduced per medical consultant review	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N10	Claim-service adjusted based on the findings of a review organization-professional consult-manual adjudication-medical or dental advisor.	297	Medical notes/report.
137	Days reduced per medical policy review	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N10	Claim-service adjusted based on the findings of a review organization-professional consult-manual adjudication-medical or dental advisor.	297	Medical notes/report.

138	Non allowable charges deleted	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M54	Missing-incomplete-invalid total charges.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
138	Non allowable charges deleted	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M79	Missing-incomplete-invalid charge	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
138	Non allowable charges deleted	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M54	Missing-incomplete-invalid total charges.	454	Procedure code for services rendered.Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
138	Non allowable charges deleted	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M79	Missing-incomplete-invalid charge	454	Procedure code for services rendered.Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
139	Services limited presumptive eligibility	177	Patient has not met the required eligibility requirements.	N30	Patient ineligible for this service.	56	Awaiting eligibility determination.
140	Room charges reduced to semi-private or ward rate	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N153	Missing-incomplete-invalid room and board rate.	65	Claim-line has been paid.
140	Room charges reduced to semi-private or ward rate	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	65	Claim-line has been paid.
140	Room charges reduced to semi-private or ward rate	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N153	Missing-incomplete-invalid room and board rate.	181	Hospitals room rate.

140	Room charges reduced to semi-private or ward rate	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	181	Hospitals room rate.
141	Bill only one months services per claim form	125	Submission-billing error(s)	N61	Rebill services on separate claims.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
143	Medicaid ID number not on state eligibility file	31	Patient cannot be identified as our insured		No Mapping Required	33	Subscriber and subscriber id not found.
143	Medicaid ID number not on state eligibility file	31	Patient cannot be identified as our insured		No Mapping Required	97	Patient eligibility not found with entity.
146	Covered days paid at intermediate care rate	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N153	Missing-incomplete-invalid room and board rate.	65	Claim-line has been paid.
146	Covered days paid at intermediate care rate	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	65	Claim-line has been paid.
146	Covered days paid at intermediate care rate	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N153	Missing-incomplete-invalid room and board rate.	456	Covered Day(s)
146	Covered days paid at intermediate care rate	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	456	Covered Day(s)
147	Claim cutback per hospital days certification	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	227	Hospital information
147	Claim cutback per hospital days certification	119	Benefit maximum for this time period or occurrence has been reached.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	227	Hospital information
148	Utilization length of stay cut off exceeded	B5	Coverage-program guidelines were not met or were exceeded.	MA32	Missing-incomplete-invalid number of covered days during the billing period.	259	Frequency of service.
148	Utilization length of stay cut off exceeded	B5	Coverage-program guidelines were not met or were exceeded.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.

148	Utilization length of stay cut off exceeded	B5	Coverage-program guidelines were not met or were exceeded.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	259	Frequency of service.
148	Utilization length of stay cut off exceeded	B5	Coverage-program guidelines were not met or were exceeded.	MA32	Missing-incomplete-invalid number of covered days during the billing period.	456	Covered Day(s)
148	Utilization length of stay cut off exceeded	B5	Coverage-program guidelines were not met or were exceeded.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	456	Covered Day(s)
148	Utilization length of stay cut off exceeded	B5	Coverage-program guidelines were not met or were exceeded.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	456	Covered Day(s)
149	Leave of absence charges not covered	78	Non-Covered days-Room charge adjustment.	M79	Missing-incomplete-invalid charge	258	Days-units for procedure-revenue code.
151	Pending recoupment of claim - system	133	The disposition of this claim-service is pending further review.		No Mapping Required	3	Claim has been adjudicated and is awaiting payment cycle.
152	Paid as billed per Department of Health Services review	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	65	Claim-line has been paid.
152	Paid as billed per Department of Health Services review	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.
155	Medicare denied ambulance service not covered by Medicaid	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	454	Procedure code for services rendered.
156	Laboratory revenue code requires corresponding lab CPT code. Enter CPT code and resubmit as a new claim	125	Submission-billing error(s)	M51	Missing-incomplete-invalid procedure code(s).	454	Procedure code for services rendered.
156	Laboratory revenue code requires corresponding lab CPT code. Enter CPT code and resubmit as a new claim	125	Submission-billing error(s)	M51	Missing-incomplete-invalid procedure code(s).	455	Revenue code for services rendered.

157	Late discharge non covered by Medicaid	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N50	Missing-incomplete-invalid discharge information.	457	Non-Covered Day(s)
159	Rebill for non-waiver services on an approved UB claim form	125	Submission-billing error(s)	N34	Incorrect claim form-format for this service.	228	Type of bill for UB claim
161	Report does not justify higher fee	150	Payer deems the information submitted does not support this level of service		No Mapping Required	297	Medical notes/report.
162	Indicate date of delivery, name of delivering physician and date patient was first seen for condition	125	Submission-billing error(s)	MA31	Missing-incomplete-invalid beginning and ending dates of the period billed.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
162	Indicate date of delivery, name of delivering physician and date patient was first seen for condition	125	Submission-billing error(s)	MA31	Missing-incomplete-invalid beginning and ending dates of the period billed.	192	Date of first service for current series-symptom-illness.
166	PENDING BUY-IN INVESTIGATION	133	The disposition of this claim-service is pending further review.		No Mapping Required	3	Claim has been adjudicated and is awaiting payment cycle.
168	BILLED AMOUNT REDUCED BY NON-COVERED CHARGE	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M79	Missing-incomplete-invalid charge	454	Procedure code for services rendered.
169	BILLED AMOUNT EQUAL TO NON-COVERED CHARGE	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M79	Missing-incomplete-invalid charge	178	Submitted charges.
169	BILLED AMOUNT EQUAL TO NON-COVERED CHARGE	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M79	Missing-incomplete-invalid charge	454	Procedure code for services rendered.

169	BILLED AMOUNT EQUAL TO NON-COVERED CHARGE	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M79	Missing-incomplete-invalid charge	596	Non-covered Charge Amount.
173	TRANSPORTATION NOT TO THE NEAREST APPROPRIATE FACILITY. PLEASE RESUBMIT AN ADJUSTMENT WITH DOCUMENTATION TO JUSTIFY TRANSPORT TO THIS FACILITY	117	Transportation is only covered to the closest facility that can provide the necessary care	N157	Transportation to-from this destination is not covered.	101	Claim was processed as adjustment to previous claim.
173	TRANSPORTATION NOT TO THE NEAREST APPROPRIATE FACILITY. PLEASE RESUBMIT AN ADJUSTMENT WITH DOCUMENTATION TO JUSTIFY TRANSPORT TO THIS FACILITY	117	Transportation is only covered to the closest facility that can provide the necessary care	N157	Transportation to-from this destination is not covered.	430	Nearest appropriate facility.
175	ADMIT HOUR REQUIRED ON OUTPATIENT CLAIM FORMAT	125	Submission-billing error(s)	N46	Missing-incomplete-invalid admission hour.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
176	REFILE ON THE APPROVED UB CLAIM FORMAT USING THE CORRECT BILL TYPE	125	Submission-billing error(s)	MA30	Missing-incomplete-invalid type of bill.	228	Type of bill for UB claim.
176	REFILE ON THE APPROVED UB CLAIM FORMAT USING THE CORRECT BILL TYPE	125	Submission-billing error(s)	MA30	Missing-incomplete-invalid type of bill.	276	UB04-HCFA-1450-1500 claim form
177	MULTIPLE PROVIDERS MAY NOT BILL ON SAME CLAIM FORM; RESUBMIT WITH ONE PROVIDER PER CLAIM FORM	125	Submission-billing error(s)	N61	Rebill services on separate claims.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

179	SERVICE COVERED BY HMO	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.
179	SERVICE COVERED BY HMO	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	585	Denied Charge or Non-covered Charge
180	MONITOR EQUIPMENT NOT PAYABLE WHEN PATIENT IN ICU/CCU	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	258	Days-units for procedure-revenue code.
181	REFILE ON OPTICAL CLAIM FORM	125	Submission-billing error(s)	N34	Incorrect claim form-format for this service.	481	Claim-submission format is invalid.
183	REFILE ON HOME HEALTH CLAIM FORMAT	125	Submission-billing error(s)	N34	Incorrect claim form-format for this service.	481	Claim-submission format is invalid.
185	REBILL SERVICE USING APPROPRIATE CODE FOR DOSAGE	153	Payer deems the information submitted does not support this dosage	M123	Missing-incomplete-invalid name, strength, or dosage of the drug furnished.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
186	TOOTH SURFACE MISSING OR INVALID. CORRECT DETAIL AND RESUBMIT CLAIM	125	Submission-billing error(s)	N75	Missing-incomplete-invalid tooth surface information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
187	QUADRANT OR ARCH INDICATOR MISSING OR INVALID	125	Submission-billing error(s)	N37	Missing-incomplete-invalid tooth number-letter.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
187	QUADRANT OR ARCH INDICATOR MISSING OR INVALID	125	Submission-billing error(s)	N37	Missing-incomplete-invalid tooth number-letter.	245	Dental quadrant-arch

188	REFILE ON INPATIENT CLAIM FORM	125	Submission-billing error(s)	N34	Incorrect claim form-format for this service.	481	Claim-submission format is invalid.
189	REFILE ON APPROVED ADA DENTAL CLAIM FORM	125	Submission-billing error(s)	N34	Incorrect claim form-format for this service.	481	Claim-submission format is invalid.
190	DATES OF SERVICE CHANGED FOR FISCAL YEAR END	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement		No Mapping Required	187	Date(s) of service.
191	MEDICAID ID NUMBER DOES NOT MATCH PATIENT NAME	140	Patient-Insured health identification number and name do not match.		No Mapping Required	30	Subscriber and subscriber id mismatched.
192	Allow once-year under age 25 without prior approval.	119	Benefit maximum for this time period or occurrence has been reached.	M90	Not covered more than once in a 12 month period.	259	Frequency of service.
193	ALLOW ONCE 2 YEARS OVER AGE 24 WITHOUT PA	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	259	Frequency of service.
193	ALLOW ONCE 2 YEARS OVER AGE 24 WITHOUT PA	119	Benefit maximum for this time period or occurrence has been reached.	N357	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	259	Frequency of service.
194	ADJUSTMENT PROCESSED TO REFLECT INCREASE IN CO-PAY	3	Co-payment Amount		No Mapping Required	20	Accepted for processing.
195	OPTICAL GOODS LESS THAN \$5.00 ARE NON-COVERED	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M79	Missing-incomplete-invalid charge	454	Procedure code for services rendered.
196	W4008 IV POLE NOT ALLOWED AFTER JANUARY 31, 1992	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing-incomplete-invalid principal procedure code.	585	Denied Charge or Non-covered Charge
196	W4008 IV POLE NOT ALLOWED AFTER JANUARY 31, 1992	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N303	Missing-incomplete-invalid principal procedure date.	585	Denied Charge or Non-covered Charge

197	REFILE ON PHYSICANS/CMS 1500 CLAIM FORMAT	125	Submission-billing error(s)	N34	Incorrect claim form-format for this service.	481	Claim-submission format is invalid.
198	REFILE ON HEARING AID FORM	125	Submission-billing error(s)	N34	Incorrect claim form-format for this service.	481	Claim-submission format is invalid.
200	PROVIDER NAME SUBMITTED DOES NOT MATCH PROVIDER NUMBER SUBMITTED	125	Submission-billing error(s)	N256	Missing-incomplete-invalid billing provider-supplier name.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
200	PROVIDER NAME SUBMITTED DOES NOT MATCH PROVIDER NUMBER SUBMITTED	125	Submission-billing error(s)	N257	Missing-incomplete-invalid billing provider-supplier primary identifier.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
200	PROVIDER NAME SUBMITTED DOES NOT MATCH PROVIDER NUMBER SUBMITTED	125	Submission-billing error(s)	N256	Missing-incomplete-invalid billing provider-supplier name.	132	Entitys Medicaid provider id. Note- This code requires use of an Entity Code.
200	PROVIDER NAME SUBMITTED DOES NOT MATCH PROVIDER NUMBER SUBMITTED	125	Submission-billing error(s)	N257	Missing-incomplete-invalid billing provider-supplier primary identifier.	132	Entitys Medicaid provider id. Note- This code requires use of an Entity Code.
201	DATE OF SERVICE IS BEFORE PROVIDER ELIGIBILITY DATE. TO INQUIRE, CONTACT DIVISION OF MEDICAL ASSISTANCE, PROVIDER ENROLLMENT, 2506 MAIL SERVICE CENTER, RALEIGH, NC 27699-2506	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present		No Mapping Required	48	Referral-authorization.
201	DATE OF SERVICE IS BEFORE PROVIDER ELIGIBILITY DATE. TO INQUIRE, CONTACT DIVISION OF MEDICAL ASSISTANCE, PROVIDER ENROLLMENT, 2506 MAIL SERVICE CENTER, RALEIGH, NC 27699-2506	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present		No Mapping Required	91	Entity not eligible-not approved for dates of service.

203	VERIFY THE DATES OF SERVICE	125	Submission-billing error(s)	MA31	Missing-incomplete-invalid beginning and ending dates of the period billed.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
203	VERIFY THE DATES OF SERVICE	125	Submission-billing error(s)	MA31	Missing-incomplete-invalid beginning and ending dates of the period billed.	187	Date(s) of service.
203	VERIFY THE DATES OF SERVICE	125	Submission-billing error(s)	MA31	Missing-incomplete-invalid beginning and ending dates of the period billed.	188	Statement from-through dates
206	A HANDWRITTEN OR STAMPED PROVIDER SIGNATURE REQUIRED	125	Submission-billing error(s)	MA81	Missing-incomplete-invalid provider-supplier signature	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
206	A HANDWRITTEN OR STAMPED PROVIDER SIGNATURE REQUIRED	125	Submission-billing error(s)	MA81	Missing-incomplete-invalid provider-supplier signature	466	Entities original signature. Note This code requires use of an Entity Code. This change effective 11-1-2011- Entitys Original Signature. Note- This code requires use of an Entity Code.
210	PAYEMENT DENIED; THERE IS NOT EVIDENCE THAT PRESENT INSTITUTION DOES NOT HAVE APPROPRIATED MEDICAL FACILITIES FOR PATIENTS TX	58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present		No Mapping Required	344	Documentation that provider of physical therapy is Medicare Part B approved.

212	DISPROPORTIONATE SHARE HOSPITAL PAYMENT INCREASE OF 5% FOR CHILDREN UNDER AGE 1 WITH CHARGES GREATER THAN ANNUAL MAXIMUM OR STAYS OVER 65 DAYS	119	Benefit maximum for this time period or occurrence has been reached.		No Mapping Required	259	Frequency of service.
215	SEND COPY OF CLAI, CERTIFICATION OF NEED AND RA TO DMA, PROGRAM INTEGRITY, INPATIENT PSYCHIATRIC, 2515 MAIL SERVICE CENTER, RALEIGH, NC 27699-2515	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes-summary-report-chart.	287	Medical necessity for service.
217	CODE PERTAINS TO PHYSICIAN ESCORT ONLY. IF BILLING FOR PHYSICIAN ESCORT, PLEASE NOTE TO AND FROM DESTINATIONS AND TIME INVOLVED	16	Claim-service lacks information which is needed for adjudication	N225	Incomplete-invalid documentation-orders-notes-summary-report-chart.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
219	INDICATE NUMBER OF MILES OUTSIDE BASE AND/OR COST/MILE	125	Submission-billing error(s)	M22	Missing-incomplete-invalid number of miles traveled.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
219	INDICATE NUMBER OF MILES OUTSIDE BASE AND/OR COST/MILE	125	Submission-billing error(s)	M22	Missing-incomplete-invalid number of miles traveled.	267	Number of miles patient was transported.
221	A NEW PRIOR APPROVAL REQUEST MUST BE SUBMITTED FOR ADDITIONAL UNITS	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	84	Service not authorized.
221	A NEW PRIOR APPROVAL REQUEST MUST BE SUBMITTED FOR ADDITIONAL UNITS	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	258	Days-units for procedure-revenue code.

223	MAXIMUM UNITS HAVE BEEN USED FOR THIS PIECE OF EQUIPMENT	108	Rent-purchase guidelines were not met. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	N362	The number of Days or Units of Service exceeds our acceptable maximum	483	Maximum coverage amount met or exceeded for benefit period.
227	THIS SERVICE REQUIRES PRIOR APPROVAL FOR YOUR PROVIDER NUMBER	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	84	Service not authorized.
232	PSYCHOSOCIAL REHAD NOT ALLOWED SAME DOS AS OLD PSYCH REHAB PROCEDURE	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	258	Days-units for procedure-revenue code.
233	INTERPRETATION AND/OR PROFESSIONAL COMPONENT IS INLUCED IN FEE FOR SERVICE	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	454	Procedure code for services rendered.
236	RESUBMIT CLAIM W/INVOICE INLCUDE RECIPIENTS NAME, MID#, IF MEDICATION, THE NAME OF MEDICATION, DOSE, SIZE VIAL/AMPULE AND NDC # USED, AND THE MONEY AMOUNT PER DOSE	16	Claim-service lacks information which is needed for adjudication	N26	Missing itemized bill	294	Supporting documentation.

237	TOTAL BILLED DOES NOT EQUAL THE SUM OF DETAILS BILLED	125	Submission-billing error(s)	M54	Missing-incomplete-invalid total charges.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
237	TOTAL BILLED DOES NOT EQUAL THE SUM OF DETAILS BILLED	125	Submission-billing error(s)	M54	Missing-incomplete-invalid total charges.	187	Date(s) of service.
238	CLAIM ADJUSTED TO REFLECT DISPROPORTIONATE SHARE RATE	76	Disproportionate Share Adjustment.		No Mapping Required	104	Processed according to plan provisions.
240	RESUBMIT PRIOR APPROVED HOURS ONLY	198	Precertification-authorization exceeded	N54	Claim information is inconsistent with precertified-authorized services	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
240	RESUBMIT PRIOR APPROVED HOURS ONLY	198	Precertification-authorization exceeded	N54	Claim information is inconsistent with precertified-authorized services	674	Authorization exceeded
244	RESUBMIT AS AN ADJUSTMENT WITH MEDICAL RECORDS ATTACHED	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes-summary-report-chart.	294	Supporting documentation.
244	RESUBMIT AS AN ADJUSTMENT WITH MEDICAL RECORDS ATTACHED	16	Claim-service lacks information which is needed for adjudication	N163	Medical Record does not support code billed per the code definition	294	Supporting documentation.
244	RESUBMIT AS AN ADJUSTMENT WITH MEDICAL RECORDS ATTACHED	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes-summary-report-chart.	317	Patients medical records.
244	RESUBMIT AS AN ADJUSTMENT WITH MEDICAL RECORDS ATTACHED	16	Claim-service lacks information which is needed for adjudication	N163	Medical Record does not support code billed per the code definition	317	Patients medical records.

252	FULL RECOUP DUE TO INVALID CONSENT FORM OR STERILIZATION GUIDELINES NOT MET	B5	Coverage-program guidelines were not met or were exceeded.	N228	Incomplete-invalid consent form.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
252	FULL RECOUP DUE TO INVALID CONSENT FORM OR STERILIZATION GUIDELINES NOT MET	B5	Coverage-program guidelines were not met or were exceeded.	N228	Incomplete-invalid consent form.	107	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)
252	FULL RECOUP DUE TO INVALID CONSENT FORM OR STERILIZATION GUIDELINES NOT MET	B5	Coverage-program guidelines were not met or were exceeded.	N228	Incomplete-invalid consent form.	666	Surgical Procedure Code
253	ADJUSTMENT DENIED, PLEASE CHECK YOUR R/A'S FOR PREVIOUS ADJUSTMENT OF THIS CLAIM	A1	Claim-Service denied	MA91	This determination is the result of the appeal you filed.	101	Claim was processed as adjustment to previous claim.
256	CLAIM CANNOT BE PROCESSED. EXPLANATION TO FOLLOW	A1	Claim-Service denied	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	1	For more detailed information, see remittance advice.
256	CLAIM CANNOT BE PROCESSED. EXPLANATION TO FOLLOW	A1	Claim-Service denied	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	104	Processed according to plan provisions.

257	REFILE AS AN ADJUSTMENT WITH ITEMIZED STATEMENT ATTACHED	16	Claim-service lacks information which is needed for adjudication	N26	Missing itemized bill	110	Claim requires pricing information.
257	REFILE AS AN ADJUSTMENT WITH ITEMIZED STATEMENT ATTACHED	16	Claim-service lacks information which is needed for adjudication	N26	Missing itemized bill	279	Claim-service must be itemized
263	ADJUSTMENT DENIED, CLAIM PAID CORRECTLY	193	Original payment decision is being maintained. This claim was processed properly the first time	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	101	Claim was processed as adjustment to previous claim.
263	ADJUSTMENT DENIED, CLAIM PAID CORRECTLY	193	Original payment decision is being maintained. This claim was processed properly the first time	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.
265	ADJUSTMENT MUST BE FILED ON HP ADJUSTMENT REQUEST FORM	125	Submission-billing error(s)	N34	Incorrect claim form-format for this service.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
266	ADJUSTMENT DENIED, COMPLETE ALL BLANKS ON THE ADJUSTMENT FORM AND RESUBMIT	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
266	ADJUSTMENT DENIED, COMPLETE ALL BLANKS ON THE ADJUSTMENT FORM AND RESUBMIT	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	294	Supporting documentation.

267	RESUBMIT STATING SPECIFIC REASON FOR ADJUSTMENT	16	Claim-service lacks information which is needed for adjudication	N1	Alert- You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
268	REFILE ADJUSTMENT WITH DMA-5016 FORM AND ALL RELATED RA'S	16	Claim-service lacks information which is needed for adjudication	N1	Alert- You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
268	REFILE ADJUSTMENT WITH DMA-5016 FORM AND ALL RELATED RA'S	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes-summary-report-chart.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
269	REFILE ADJUSTMENT WITH MEDICAL RECORDS. PLEASE RESUBMIT WITH NECESSARY INFORMATION ALONG WITH A COPY OF THE ORIGINAL CLAIMS RA	16	Claim-service lacks information which is needed for adjudication	M127	Missing patient medical record for this service.	101	Claim was processed as adjustment to previous claim.
269	REFILE ADJUSTMENT WITH MEDICAL RECORDS. PLEASE RESUBMIT WITH NECESSARY INFORMATION ALONG WITH A COPY OF THE ORIGINAL CLAIMS RA	16	Claim-service lacks information which is needed for adjudication	M127	Missing patient medical record for this service.	123	Additional information requested from entity.

269	REFILE ADJUSTMENT WITH MEDICAL RECORDS. PLEASE RESUBMIT WITH NECESSARY INFORMATION ALONG WITH A COPY OF THE ORIGINAL CLAIMS RA	16	Claim-service lacks information which is needed for adjudication	M127	Missing patient medical record for this service.	297	Medical notes/report.
271	REFILE ADJUSTMENT WITH ALL RELATED MEDICARE VOUCHERS. RESUBMIT WITH NECESSARY INFORMATION ALONG WITH A COPY OF ORIGINAL CLAIMS RA	148	Information from another provider was not provided or was insufficient-incomplete	N29	Missing documentation-orders-notes- summary- report- chart.	101	Claim was processed as adjustment to previous claim.
271	REFILE ADJUSTMENT WITH ALL RELATED MEDICARE VOUCHERS. RESUBMIT WITH NECESSARY INFORMATION ALONG WITH A COPY OF ORIGINAL CLAIMS RA	148	Information from another provider was not provided or was insufficient-incomplete	N29	Missing documentation-orders-notes- summary- report- chart.	123	Additional information requested from entity.
271	REFILE ADJUSTMENT WITH ALL RELATED MEDICARE VOUCHERS. RESUBMIT WITH NECESSARY INFORMATION ALONG WITH A COPY OF ORIGINAL CLAIMS RA	148	Information from another provider was not provided or was insufficient-incomplete	N29	Missing documentation-orders-notes- summary- report- chart.	286	Other payer's Explanation of Benefits/Payment information.
272	ADJUSTMENT REQUEST DENIED, ADJUSTMENTS ARE NOT PROCESSED FOR RATE CHANGES	138	Appeal procedures not followed or time limits not met	M51	Missing-incomplete-invalid procedure code(s).	101	Claim was processed as adjustment to previous claim.
273	FULL RECOUPMENT, PER YOUR REQUEST	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.

275	FULL RECOUPMENT, CLAIM HAS BEEN SUBMITTED	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.
277	FULL RECOUPMENT, PAID FOR WRONG RECIPIENT	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.
278	FULL RECOUPMENT, PAID FOR WRONG RECIPIENT	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.
280	FULL RECOUPMENT PER MEDICAL OR POLICY REVIEW	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.
281	FULL RECOUPMENT, DUPLICATE PAYMENT	18	Exact duplicate claim-service	M86	Service denied because payment already made for same-similar procedure within set time frame.	54	Duplicate of a previously processed claim-line.
283	SERVICE CODE MISSING OR INVALID	125	Submission-billing error(s)	M51	Missing-incomplete-invalid procedure code(s).	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
283	SERVICE CODE MISSING OR INVALID	125	Submission-billing error(s)	N188	The approved level of care does not match the procedure code submitted.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
284	DISPENSING DATE IS BEFORE NDC NUMBER WAS PACED ON MARKET	B5	Coverage-program guidelines were not met or were exceeded.		No Mapping Required	107	Processed according to contract-plan provisions.
285	ADJUSTMENT DENIED-CHANGE IN PATIENT LIABILITY SHOULD HAVE BEEN ON CLAIM BEFORE SUBMISSION	125	Submission-billing error(s)	N58	Missing-incomplete-invalid patient liability amount.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

287	ADJUSTMENT DENIED, REFERENCE ONLY ONE CLAIM PER FORM. REFILE ADJSUTMENTS SEPERATELY	125	Submission-billing error(s)	N1	Alert - You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	101	Claim was processed as adjustment to previous claim.
287	ADJUSTMENT DENIED, REFERENCE ONLY ONE CLAIM PER FORM. REFILE ADJSUTMENTS SEPERATELY	125	Submission-billing error(s)	N61	Rebill services on separate claims.	101	Claim was processed as adjustment to previous claim.
288	ADJUSTMENT DENIED; DMA FILES INDICATE COMMERCIAL INSURANCE. REFILE WITH INSURANCE PAYMENT/DENIAL VOUCHER	148	Information from another provider was not provided or was insufficient-incomplete	N61	Rebill services on separate claims.	275	Claim
292	QUALIFIED MEDICARE BENE-MQB RECIPIENT. MEDICARE PAYMENT MUST BE INDICATED, EITHER AS MEDICARE CROSSOVER FOR DOS PRIOR TO 10-1-02 OR THIRD PARTY IF DOS 10-1-2002 OR AFTER	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	107	Processed according to contract-plan provisions.
292	QUALIFIED MEDICARE BENE-MQB RECIPIENT. MEDICARE PAYMENT MUST BE INDICATED, EITHER AS MEDICARE CROSSOVER FOR DOS PRIOR TO 10-1-02 OR THIRD PARTY IF DOS 10-1-2002 OR AFTER	22	This care may be covered by another payer per coordination of benefits.	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	107	Processed according to contract-plan provisions.

292	QUALIFIED MEDICARE BENE-MQB RECIPIENT. MEDICARE PAYMENT MUST BE INDICATED, EITHER AS MEDICARE CROSSOVER FOR DOS PRIOR TO 10-1-02 OR THIRD PARTY IF DOS 10-1-2002 OR AFTER	22	This care may be covered by another payer per coordination of benefits.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.
292	QUALIFIED MEDICARE BENE-MQB RECIPIENT. MEDICARE PAYMENT MUST BE INDICATED, EITHER AS MEDICARE CROSSOVER FOR DOS PRIOR TO 10-1-02 OR THIRD PARTY IF DOS 10-1-2002 OR AFTER	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	116	Claim submitted to incorrect payer.
292	QUALIFIED MEDICARE BENE-MQB RECIPIENT. MEDICARE PAYMENT MUST BE INDICATED, EITHER AS MEDICARE CROSSOVER FOR DOS PRIOR TO 10-1-02 OR THIRD PARTY IF DOS 10-1-2002 OR AFTER	22	This care may be covered by another payer per coordination of benefits.	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	116	Claim submitted to incorrect payer.
292	QUALIFIED MEDICARE BENE-MQB RECIPIENT. MEDICARE PAYMENT MUST BE INDICATED, EITHER AS MEDICARE CROSSOVER FOR DOS PRIOR TO 10-1-02 OR THIRD PARTY IF DOS 10-1-2002 OR AFTER	22	This care may be covered by another payer per coordination of benefits.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	116	Claim submitted to incorrect payer.

292	QUALIFIED MEDICARE BENE-MQB RECIPIENT. MEDICARE PAYMENT MUST BE INDICATED, EITHER AS MEDICARE CROSSOVER FOR DOS PRIOR TO 10-1-02 OR THIRD PARTY IF DOS 10-1-2002 OR AFTER	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	655	Total Medicare Paid Amount
292	QUALIFIED MEDICARE BENE-MQB RECIPIENT. MEDICARE PAYMENT MUST BE INDICATED, EITHER AS MEDICARE CROSSOVER FOR DOS PRIOR TO 10-1-02 OR THIRD PARTY IF DOS 10-1-2002 OR AFTER	22	This care may be covered by another payer per coordination of benefits.	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	655	Total Medicare Paid Amount
292	QUALIFIED MEDICARE BENE-MQB RECIPIENT. MEDICARE PAYMENT MUST BE INDICATED, EITHER AS MEDICARE CROSSOVER FOR DOS PRIOR TO 10-1-02 OR THIRD PARTY IF DOS 10-1-2002 OR AFTER	22	This care may be covered by another payer per coordination of benefits.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	655	Total Medicare Paid Amount
293	ONLY ONE UNIT OF SERVICE ALLOWED PER DETAIL, UNITS CHANGED TO FACILITATE PROCESSING	125	Submission-billing error(s)	N63	Rebill services on separate claim lines.	259	Frequency of service.
294	RESUBMIT PRIOR APPROVED DATES OF SERVICE ONLY	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	187	Date(s) of service.

295	NUMBER OF MILES BILLED IS EXCESSIVE ACCORDING TO POINT OF PICK UP AND DESTINATION POINT LISTED ON YOUR CLAIM. PLEASE CORRECT MILEAGE AND RESUBMIT CLAIM	125	Submission-billing error(s)	M22	Missing-incomplete-invalid number of miles traveled.	267	Number of miles patient was transported.
296	YOUR CLAIM IS BEING SPLIT TO FACILITATE PROCESSING; IT WILL BE RESUBMITTED FOR YOU AS MULTIPLE CLAIMS. PLEASE WATCH FOR THESE CLAIMS ON FUTURE R/A'S	101	Predetermination: anticipated payment upon completion of services or claim adjudication.	MA15	Alert- Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.	72	Claim contains split payment.
296	YOUR CLAIM IS BEING SPLIT TO FACILITATE PROCESSING; IT WILL BE RESUBMITTED FOR YOU AS MULTIPLE CLAIMS. PLEASE WATCH FOR THESE CLAIMS ON FUTURE R/A'S	101	Predetermination: anticipated payment upon completion of services or claim adjudication.	N185	Alert- Do not resubmit this claim-service	72	Claim contains split payment.
297	CLAIM DENIED- WILL BE PAID AS A FINANCIAL ITEM ON FUTURE REMITTANCE ADVICE	101	Predetermination: anticipated payment upon completion of services or claim adjudication.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	3	Claim has been adjudicated and is awaiting payment cycle.
298	CATASTROPHIC PROVIDERS MUST INDICATE MEDICARE PAYMENTS FOR SERVICES TO CATASTROPHIC RECIPIENTS, EITHER AS CROSSOVER IF DOS IS PRIOR TO 10-1-02 OR THIRD PARTY IF 10/1/02 OR AFTER	109	Claim not covered by this payer-contractor. You must send the claim to the correct payer-contractor.	N95	This provider type - provider specialty may not bill this service.	91	Entity not eligible-not approved for dates of service.
302	PAYMENT REDUCED BY NEGATIVE MEDICARE REIMBURSEMENT	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	107	Processed according to contract-plan provisions.

302	PAYMENT REDUCED BY NEGATIVE MEDICARE REIMBURSEMENT	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.
309	SERVICE IS INCLUDED IN CORE	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	454	Procedure code for services rendered.
325	PROCEDURE, PROCEDURE-MODIFIER COMBINATION OR RATE NOT COVERED FOR THIS DATE OF SERVICE	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing-incomplete-invalid principal procedure code.	454	Procedure code for services rendered.
325	PROCEDURE, PROCEDURE-MODIFIER COMBINATION OR RATE NOT COVERED FOR THIS DATE OF SERVICE	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N188	The approved level of care does not match the procedure code submitted	454	Procedure code for services rendered.
325	PROCEDURE, PROCEDURE-MODIFIER COMBINATION OR RATE NOT COVERED FOR THIS DATE OF SERVICE	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N301	Missing-incomplete-invalid procedure date(s).	454	Procedure code for services rendered.
327	CODE MULTIPLE LAB TEST ON THE SAME DAY TO EQUIVALENT PANEL CODE	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	454	Procedure code for services rendered.
356	MAPPED ATTENDING PROVIDER ID IS NOT ELIBIBLE ON SERVICE DATE	A1	Claim-Service denied	N253	Missing-incomplete-invalid attending provider primary identifier.	91	Entity not eligible-not approved for dates of service.

356	MAPPED ATTENDING PROVIDER ID IS NOT ELIBIBLE ON SERVICE DATE	A1	Claim-Service denied	N253	Missing-incomplete-invalid attending provider primary identifier.	562	Entity's National Provider Identifier (NPI)
430	CLAIM REFERRED TO THE DIVISION OF MEDICAL ASSISTANCE FOR PROCESSING INFORMATION. THE CLAIM WILL BE RESUBMITTED FOR YOU	133	The disposition of this claim-service is pending further review.	N185	Alert- Do not resubmit this claim-service	297	Medical notes/report.
458	LESS SEVERE DUPLICATE. SAME PROCEDURE CODE PROFESSIONAL DENTAL.	18	Exact duplicate claim-service	M86	Service denied because payment already made for same-similar procedure within set time frame.	54	Duplicate of a previously processed claim-line.
459	Less severe dupe-same DOS-same admit hour.	18	Exact duplicate claim-service	M86	Service denied because payment already made for same-similar procedure within set time frame.	54	Duplicate of a previously processed claim-line.
478	Suspect dupe-dental sys plug.	18	Exact duplicate claim-service	M86	Service denied because payment already made for same-similar procedure within set time frame.	54	Duplicate of a previously processed claim-line.
488	Less severe dupe-dental sys plug.	18	Exact duplicate claim-service	M86	Service denied because payment already made for same-similar procedure within set time frame.	54	Duplicate of a previously processed claim-line.
498	Exact dupe dental sys plug.	18	Exact duplicate claim-service	M86	Service denied because payment already made for same-similar procedure within set time frame.	54	Duplicate of a previously processed claim-line.
524	Records previously submitted are insufficient. Resubmit as an adjustment with attending physician records specific to denied DOS & original RA copy	16	Claim-service lacks information which is needed for adjudication	M127	Missing patient medical record for this service.	123	Additional information requested from entity.

524	RECORDS PREVIOUSLY SUBMITTED ARE INSUFFICIENT. RESUBMIT AS AN ADJUSTMENT WITH ATTENDING PHYSICAN RECORDS SPECIFIC TO DENIED DOS & ORIGINAL RA COPY	16	Claim-service lacks information which is needed for adjudication	N163	Medical Record does not support code billed per the code definition.	123	Additional information requested from entity.
524	RECORDS PREVIOUSLY SUBMITTED ARE INSUFFICIENT. RESUBMIT AS AN ADJUSTMENT WITH ATTENDING PHYSICAN RECORDS SPECIFIC TO DENIED DOS & ORIGINAL RA COPY	16	Claim-service lacks information which is needed for adjudication	M127	Missing patient medical record for this service.	295	Attending physician report.
524	RECORDS PREVIOUSLY SUBMITTED ARE INSUFFICIENT. RESUBMIT AS AN ADJUSTMENT WITH ATTENDING PHYSICAN RECORDS SPECIFIC TO DENIED DOS & ORIGINAL RA COPY	16	Claim-service lacks information which is needed for adjudication	N163	Medical Record does not support code billed per the code definition.	295	Attending physician report.
534	Copay previously deducted for this date of service.	3	Co-payment Amount		No Mapping Required	104	Processed according to plan provisions.
538	Procedure not allowed in conjunction with general anesthesia.	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N203	Service not payable with other service rendered on the same date.	258	Days-units for procedure-revenue code.

550	EXCEEDS MAXIMUM OF 12 UNITS PER CALENDAR WEEK	119	Benefit maximum for this time period or occurrence has been reached.	N357	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	259	Frequency of service.
550	EXCEEDS MAXIMUM OF 12 UNITS PER CALENDAR WEEK	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum	259	Frequency of service.
569	SERVICE DENIED; PROCEDURE CODE OR PROCEDURE CODE-MODIFIER COMBINATION REQUIRING PA DOES NOT MATCH THE CODE OR CODE-MODIFIER BILLED BY THE PRIMARY PHYSICIAN FOR THIS DATE	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	453	Procedure code modifier(s) for service(s) rendered.
569	SERVICE DENIED; PROCEDURE CODE OR PROCEDURE CODE-MODIFIER COMBINATION REQUIRING PA DOES NOT MATCH THE CODE OR CODE-MODIFIER BILLED BY THE PRIMARY PHYSICIAN FOR THIS DATE	197	Precertification-authorization-notification absent.	N188	The approved level of care does not match the procedure code submitted.	453	Procedure code modifier(s) for service(s) rendered.
569	SERVICE DENIED; PROCEDURE CODE OR PROCEDURE CODE-MODIFIER COMBINATION REQUIRING PA DOES NOT MATCH THE CODE OR CODE-MODIFIER BILLED BY THE PRIMARY PHYSICIAN FOR THIS DATE	197	Precertification-authorization-notification absent.	N56	Procedure code billed is not correct-valid for the services billed or the date of service billed.	453	Procedure code modifier(s) for service(s) rendered.
572	SERVICE DENIED; PA HAS NOT BEEN OBTAINED BY THE PRIMARY PHYSICIAN	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	48	Referral-authorization.

572	SERVICE DENIED; PA HAS NOT BEEN OBTAINED BY THE PRIMARY PHYSICIAN	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	84	Service not authorized.
574	PROCEDURE OR PROCEDURE-MODIFIER COMBINATION IS NOT COVERED FOR THE DATE OF PROCESSING	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing-incomplete-invalid principal procedure code.	453	Procedure Code Modifier(s) for Service(s) Rendered.
574	PROCEDURE OR PROCEDURE-MODIFIER COMBINATION IS NOT COVERED FOR THE DATE OF PROCESSING	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N301	Missing-incomplete-invalid procedure date(s).	453	Procedure Code Modifier(s) for Service(s) Rendered.
574	PROCEDURE OR PROCEDURE-MODIFIER COMBINATION IS NOT COVERED FOR THE DATE OF PROCESSING	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing-incomplete-invalid principal procedure code.	457	Non-Covered Day(s).
574	PROCEDURE OR PROCEDURE-MODIFIER COMBINATION IS NOT COVERED FOR THE DATE OF PROCESSING	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N301	Missing-incomplete-invalid procedure date(s).	457	Non-Covered Day(s).
575	PROCEDURE OR PRECEDURE-MODIFIER COMBINATION IS NOT COVERED FOR THE DATE OF RECEIPT	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing-incomplete-invalid principal procedure code.	453	Procedure Code Modifier(s) for Service(s) Rendered.
575	PROCEDURE OR PRECEDURE-MODIFIER COMBINATION IS NOT COVERED FOR THE DATE OF RECEIPT	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N301	Missing-incomplete-invalid procedure date(s).	453	Procedure Code Modifier(s) for Service(s) Rendered.
575	PROCEDURE OR PRECEDURE-MODIFIER COMBINATION IS NOT COVERED FOR THE DATE OF RECEIPT	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing-incomplete-invalid principal procedure code.	457	Non-Covered Day(s).

575	PROCEDURE OR PRECEDURE-MODIFIER COMBINATION IS NOT COVERED FOR THE DATE OF RECEIPT	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N301	Missing-incomplete-invalid procedure date(s).	457	Non-Covered Day(s).
589	OTHER PROCEDURE CODE 4 IS INVALID	125	Submission-billing error(s)	N56	Procedure code billed is not correct-valid for the services billed or the date of service billed.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
589	OTHER PROCEDURE CODE 4 IS INVALID	125	Submission-billing error(s)	N56	Procedure code billed is not correct-valid for the services billed or the date of service billed.	490	Other procedure code for service(s) rendered
590	OTHER PROCEDURE CODE 5 IS INVALID	125	Submission-billing error(s)	N56	Procedure code billed is not correct-valid for the services billed or the date of service billed.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
590	OTHER PROCEDURE CODE 5 IS INVALID	125	Submission-billing error(s)	N56	Procedure code billed is not correct-valid for the services billed or the date of service billed.	490	Other procedure code for service(s) rendered
593	OTHER PROCEDURE CODE 6 IS INVALID	125	Submission-billing error(s)	N56	Procedure code billed is not correct-valid for the services billed or the date of service billed.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
593	OTHER PROCEDURE CODE 6 IS INVALID	125	Submission-billing error(s)	N56	Procedure code billed is not correct-valid for the services billed or the date of service billed.	490	Other procedure code for service(s) rendered.

598	General anesthesia for sterilization billed in conjunction with general anesthesia for delivery is being reimbursed to reflect time only.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	454	Procedure code for services rendered.
600	ALLOW ONE FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSIS EVERY 364 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	259	Frequency of service.
610	TOOTH NUMBER MISSING OR INVALID. CORRECT DETAIL AND RESUBMIT CLAIM	125	Submission-billing error(s)	N37	Missing-incomplete-invalid tooth number-letter.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
610	TOOTH NUMBER MISSING OR INVALID. CORRECT DETAIL AND RESUBMIT CLAIM	125	Submission-billing error(s)	N37	Missing-incomplete-invalid tooth number-letter.	242	Tooth numbers, surfaces, and-or quadrants involved.
627	ONE PERIAPICAL SINGLE FIRST FILM PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	612	Per Day Limit Amount
673	Units for monthly rental should be billed one per month regardless of the dates of service.	125	Submission-billing error(s)	M53	Missing-incomplete-invalid days or units of service.	258	Days-units for procedure-revenue code.
673	Units for monthly rental should be billed one per month regardless of the dates of service.	125	Submission-billing error(s)	M53	Missing-incomplete-invalid days or units of service.	259	Frequency of service.
673	Units for monthly rental should be billed one per month regardless of the dates of service.	125	Submission-billing error(s)	M53	Missing-incomplete-invalid days or units of service.	476	Missing or invalid units of service

685	Health check services are for Medicaid recipients birth thru age 20 only.	6	The procedure-revenue code is inconsistent with the patients age		No Mapping Required	475	Procedure code not valid for patient age.
771	Procedure allowed once in a lifetime.	149	Lifetime benefit maximum has been reached for this service-benefit category	N117	This service is paid only once in a patients lifetime.	259	Frequency of service.
795	Services recouped. Documentation shows a different provider as admitting-attending physician. Rebill as a consult.	125	Submission-billing error(s)	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.
795	Services recouped. Documentation shows a different provider as admitting-attending physician. Rebill as a consult.	125	Submission-billing error(s)	MA67	Correction to a prior claim.	454	Procedure code for services rendered.
810	Adjustment denied; adjustment can not be processed without corrected information. Refile adjustment with a complete, legible, corrected claim copy.	125	Submission-billing error(s)	N3	Missing consent form.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
810	Adjustment denied; adjustment can not be processed without corrected information. Refile adjustment with a complete, legible, corrected claim copy.	125	Submission-billing error(s)	N3	Missing consent form.	294	Supporting documentation.
811	Adjustment denied, attach copy of recipient Medicaid card for these dates and forward to Division of Medical Assistance, 1985 Umstead Dr. Box 29529 Raleigh NC 27626-0529.	177	Patient has not met the required eligibility requirements.	N30	Patient ineligible for this service.	123	Additional information requested from entity.
812	Adjustment denied, please refile with all related R-A's including original processing.	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes- summary- report- chart.	294	Supporting documentation.

813	This Home Health claim has been adjusted to reflect the rate increase effective 07-01-92.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N144	The rate changed during the dates of service billed.	65	Claim-line has been paid.
813	This Home Health claim has been adjusted to reflect the rate increase effective 07-01-92.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	65	Claim-line has been paid.
813	This Home Health claim has been adjusted to reflect the rate increase effective 07-01-92.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N144	The rate changed during the dates of service billed.	101	Claim was processed as adjustment to previous claim
813	This Home Health claim has been adjusted to reflect the rate increase effective 07-01-92.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	101	Claim was processed as adjustment to previous claim

815	Claim adjusted to reflect 4.2% increase effective 1-1-90.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N144	The rate changed during the dates of service billed.	65	Claim-line has been paid.
815	Claim adjusted to reflect 4.2% increase effective 1-1-90.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	65	Claim-line has been paid.
815	Claim adjusted to reflect 4.2% increase effective 1-1-90.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N144	The rate changed during the dates of service billed.	101	Claim was processed as adjustment to previous claim
815	Claim adjusted to reflect 4.2% increase effective 1-1-90.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	101	Claim was processed as adjustment to previous claim
819	Both the 'from' and 'to' date of service must be the date of delivery when billing total ob package or delivery codes.	125	Submission-billing error(s)	M53	Missing-incomplete-invalid days or units of service.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

819	Both the 'from' and 'to' date of service must be the date of delivery when billing total ob package or delivery codes.	125	Submission-billing error(s)	MA31	Missing-incomplete-invalid beginning and ending dates of the period billed.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
819	Both the 'from' and 'to' date of service must be the date of delivery when billing total ob package or delivery codes.	125	Submission-billing error(s)	M53	Missing-incomplete-invalid days or units of service.	188	Statement from-through dates.
819	Both the 'from' and 'to' date of service must be the date of delivery when billing total ob package or delivery codes.	125	Submission-billing error(s)	MA31	Missing-incomplete-invalid beginning and ending dates of the period billed.	188	Statement from-through dates.
824	The sterilization consent form is completed incorrectly. Please correct by completing or correcting the procedure code spaces.	16	Claim-service lacks information which is needed for adjudication	N3	Missing consent form..	465	Principal Procedure Code for Service(s) Rendered.
828	Disproportionate share hospital payment increase of 5% for children under age 6 with charges greater than annual maximum or stays over 65 days.	76	Disproportionate Share Adjustment.		No Mapping Required	104	Processed according to plan provisions.
829	All claims and R-A's related to interim billings must be attached to adjustment request.	16	Claim-service lacks information which is needed for adjudication	N1	Alert- You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
829	All claims and R-A's related to interim billings must be attached to adjustment request.	16	Claim-service lacks information which is needed for adjudication	N3	Missing consent form.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

830	Non-disproportionate share hospital payment increase of 5% for children under age 1 with charges greater than annual maximum or stays over 65 days.	76	Disproportionate Share Adjustment.		No Mapping Required	104	Processed according to plan provisions.
834	This previously paid claim has been recouped and repaid in this check write to include the additional disproportionate share 5%.	76	Disproportionate Share Adjustment.		No Mapping Required	104	Processed according to plan provisions.
835	SUBSEQUENT BILLING OF REPAIR CODE HAS BEEN PAID AT THE SECONDARY MAXIMUM ALLOWED RATE.	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note- Refer to the 835 Healthcare Policy identification Segment (loop 2110 Service Payment Information REF), if present	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	259	Frequency of service.
835	SUBSEQUENT BILLING OF REPAIR CODE HAS BEEN PAID AT THE SECONDARY MAXIMUM ALLOWED RATE.	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note- Refer to the 835 Healthcare Policy identification Segment (loop 2110 Service Payment Information REF), if present	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	453	Procedure Code Modifier(s) for Service(s) Rendered
860	This code is non-covered for paternity testing.	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M79	Missing-incomplete-invalid charge	454	Procedure code for services rendered.
875	Full recoup, rebill using the correct type of service.	125	Submission-billing error(s)	MA67	Correction to a prior claim.	250	Type of service.
890	Paid at Medicaid per diem rate; paid maximum allowable.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	65	Claim-line has been paid.

890	Paid at Medicaid per diem rate; paid maximum allowable.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	483	Maximum coverage amount met or exceeded for benefit period
902	Claim paid - EAC price adjusted.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N45	Payment based on authorized amount.	65	Claim-line has been paid.
902	Claim paid - EAC price adjusted.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	65	Claim-line has been paid.
902	Claim paid - EAC price adjusted.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N45	Payment based on authorized amount.	107	Processed according to contract-plan provisions.
902	Claim paid - EAC price adjusted.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.
903	Claim paid - MAC price adjusted.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N45	Payment based on authorized amount.	65	Claim-line has been paid.
903	Claim paid - MAC price adjusted.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	65	Claim-line has been paid.
903	Claim paid - MAC price adjusted.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N45	Payment based on authorized amount.	107	Processed according to contract-plan provisions.
903	Claim paid - MAC price adjusted.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.
904	Claim paid - AWP price adjusted.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N45	Payment based on authorized amount.	65	Claim-line has been paid.

904	Claim paid - AWP price adjusted.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.
907	Full recoupment per pharmacy of record review.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.
909	Please resubmit claim with both mileage and base fee coded to the same level of service, (ie: ALS or BLS).	150	Payer deems the information submitted does not support this level of service	M22	Missing-incomplete-invalid number of miles traveled.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
910	Rebill with form 5016 indicating patient liability amount.	125	Submission-billing error(s)	N34	Incorrect claim form-format for this service.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
910	Rebill with form 5016 indicating patient liability amount.	125	Submission-billing error(s)	N58	Missing-incomplete-invalid patient liability amount	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
911	Denied CMS termination.	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service.		No Mapping Required	104	Processed according to plan provisions.
912	Provider must enroll with the Division of Medical Assistance. Visit our website for an enrollment packet or contact Provider Services at 1 800 688 6696 Option 3.	133	The disposition of this claim-service is pending further review.	MA07	Alert- The claim information has also been forwarded to Medicaid for review	16	Claim-encounter has been forwarded to entity.

916	Resubmit claim with the post-evaluation report and applicable invoices.	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes- summary- report- chart.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
916	Resubmit claim with the post-evaluation report and applicable invoices.	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes- summary- report- chart.	294	Supporting documentation.
920	CLIA certification number is unknown to NC Medicaid. Contact your state CLIA authority. NC providers contact NC DFS, CLIA, PO Box 29530 Raleigh, NC 27626-0530.	125	Submission-billing error(s)	MA120	Missing-incomplete-invalid CLIA certification number.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
920	CLIA certification number is unknown to NC Medicaid. Contact your state CLIA authority. NC providers contact NC DFS, CLIA, PO Box 29530 Raleigh, NC 27626-0530.	125	Submission-billing error(s)	MA120	Missing-incomplete-invalid CLIA certification number.	142	Entitys license-certification number.
920	CLIA certification number is unknown to NC Medicaid. Contact your state CLIA authority. NC providers contact NC DFS, CLIA, PO Box 29530 Raleigh, NC 27626-0530.	125	Submission-billing error(s)	MA120	Missing-incomplete-invalid CLIA certification number.	630	Referring CLIA Number
927	Code is to cover 24 hours, therefore only one unit allowed per day.	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	259	Frequency of service.
927	Code is to cover 24 hours, therefore only one unit allowed per day.	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	612	Per Day Limit Amount

932	CLIA cert info could not be verified. Verify CLIA number on summary page. Contact your state CLIA authority-NC providers contact NC DFS CLIA PO BOX 29530 Raleigh NC 27626.	125	Submission-billing error(s)	MA120	Missing-incomplete-invalid CLIA certification number.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
932	CLIA cert info could not be verified. Verify CLIA number on summary page. Contact your state CLIA authority-NC providers contact NC DFS CLIA PO BOX 29530 Raleigh NC 27626.	125	Submission-billing error(s)	MA120	Missing-incomplete-invalid CLIA certification number.	142	Entitys license-certification number.
932	CLIA cert info could not be verified. Verify CLIA number on summary page. Contact your state CLIA authority-NC providers contact NC DFS CLIA PO BOX 29530 Raleigh NC 27626.	125	Submission-billing error(s)	MA120	Missing-incomplete-invalid CLIA certification number.	630	Referring CLIA Number
936	CLIA cert not valid for DOS-level. If you have only 1 CLIA #, contact agency that issued cert. If multi CLIA#, send copy of cert-claim & inquiry form to HP Provider Services.	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service.	MA120	Missing-incomplete-invalid CLIA certification number.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
936	CLIA cert not valid for DOS-level. If you have only 1 CLIA #, contact agency that issued cert. If multi CLIA#, send copy of cert-claim & inquiry form to HP Provider Services.	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service.	MA120	Missing-incomplete-invalid CLIA certification number.	142	Entitys license-certification number.

936	CLIA cert not valid for DOS-level. If you have only 1 CLIA #, contact agency that issued cert. If multi CLIA#, send copy of cert-claim & inquiry form to HP Provider Services.	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service.	MA120	Missing-incomplete-invalid CLIA certification number.	630	Referring CLIA Number
940	The recipient first initial and last name required.	125	Submission-billing error(s)	MA36	Missing-incomplete-invalid patient name	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
940	The recipient first initial and last name required.	125	Submission-billing error(s)	MA36	Missing-incomplete-invalid patient name	125	Entity's name.
942	Prescriber name or DEA number is required .	125	Submission-billing error(s)	N31	Missing-incomplete-invalid prescribing provider identifier.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
942	Prescriber name or DEA number is required .	125	Submission-billing error(s)	N31	Missing-incomplete-invalid prescribing provider identifier.	150	Entity's drug enforcement agency (DEA) number.
943	Date of claim is prior to date of service.	110	Billing date predates service date		No Mapping Required	88	Entity not eligible for benefits for submitted dates of service. Note- This code requires use of an Entity Code.
944	Quantity dispensed(if IV-give bags) and days supply(not dosage) req.; or total quantity mismatch on detail line 0-9 vs. compound items (excludes tabs-cap-pwds.).	154	Payer deems the information submitted does not support this days supply	M119	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
945	Total amount billed (drug cost + disp. fee) is required in the dollars-cents field & must be greater than TPL-Medicare payment in other covered field. Do not bill co-pay-ded.	125	Submission-billing error(s)	M54	Missing-incomplete-invalid total charges.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

946	Compound info req. give drug name, strength, NDC, Mfg,quantity and cost of all ingredients at bottom of form. On detail 0-9 put compd. drug name, if IV-give formula per bag.	125	Submission-billing error(s)	M119	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
946	Compound info req. give drug name, strength, NDC, Mfg,quantity and cost of all ingredients at bottom of form. On detail 0-9 put compd. drug name, if IV-give formula per bag.	125	Submission-billing error(s)	M123	Missing-incomplete-invalid name, strength, or dosage of the drug furnished.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
946	Compound info req. give drug name, strength, NDC, Mfg,quantity and cost of all ingredients at bottom of form. On detail 0-9 put compd. drug name, if IV-give formula per bag.	125	Submission-billing error(s)	M119	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	216	Drug information.
946	Compound info req. give drug name, strength, NDC, Mfg,quantity and cost of all ingredients at bottom of form. On detail 0-9 put compd. drug name, if IV-give formula per bag.	125	Submission-billing error(s)	M123	Missing-incomplete-invalid name, strength, or dosage of the drug furnished.	216	Drug information.
947	The date of service is required on claim form.	125	Submission-billing error(s)	MA06	Missing-incomplete-invalid beginning and-or ending date(s).	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
947	The date of service is required on claim form.	125	Submission-billing error(s)	MA06	Missing-incomplete-invalid beginning and-or ending date(s).	187	Date(s) of service.
948	Legible drug name, NDC,MFG. Must be indicated on a legible claim form and-or drug name-strength-NDC mismatch.	125	Submission-billing error(s)	M119	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	216	Drug information.

948	Legible drug name, NDC,MFG. Must be indicated on a legible claim form and-or drug name-strength-NDC mismatch.	125	Submission-billing error(s)	M123	Missing-incomplete-invalid name, strength, or dosage of the drug furnished.	216	Drug information.
948	Legible drug name, NDC,MFG. Must be indicated on a legible claim form and-or drug name-strength-NDC mismatch.	125	Submission-billing error(s)	M119	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	217	Drug name, strength and dosage form.
948	Legible drug name, NDC,MFG. Must be indicated on a legible claim form and-or drug name-strength-NDC mismatch.	125	Submission-billing error(s)	M123	Missing-incomplete-invalid name, strength, or dosage of the drug furnished.	217	Drug name, strength and dosage form.
948	Legible drug name, NDC,MFG. Must be indicated on a legible claim form and-or drug name-strength-NDC mismatch.	125	Submission-billing error(s)	M119	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	218	NDC number.
948	Legible drug name, NDC,MFG. Must be indicated on a legible claim form and-or drug name-strength-NDC mismatch.	125	Submission-billing error(s)	M123	Missing-incomplete-invalid name, strength, or dosage of the drug furnished.	218	NDC number.
949	Prescriptions on form must be for same month.	125	Submission-billing error(s)	MA06	Missing-incomplete-invalid beginning and-or ending date(s).	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
950	Claim denied: HP will refile-upon receipt of info from mfg.	133	The disposition of this claim-service is pending further review.	N10	Claim-service adjusted based on the findings of a review organization-professional consult-manual adjudication-medical or dental advisor.	42	Awaiting related charges.

950	Claim denied: HP will refile-upon receipt of info from mfg.	133	The disposition of this claim-service is pending further review.	N185	Alert- Do not resubmit this claim-service	42	Awaiting related charges.
951	Adjustment due to a payment error discovered from a drug rebate inquiry.	B5	Coverage-program guidelines were not met or were exceeded.		No Mapping Required	107	Processed according to contract-plan provisions.
953	Individual has restricted coverage - Medicaid only pays the part B premium.	109	Claim not covered by this payer-contractor. You must send the claim to the correct payer-contractor.		No Mapping Required	84	Service not authorized
954	Level of Service billed is not documented. Please refile as an adjustment with further documentation or using the non-emergent codes.	150	Payer deems the information submitted does not support this level of service	N1	Alert- You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
954	Level of Service billed is not documented. Please refile as an adjustment with further documentation or using the non-emergent codes.	150	Payer deems the information submitted does not support this level of service	N29	Missing documentation-orders-notes- summary- report- chart.	294	Supporting documentation
960	Please specify the name of the medication given in this injection.	125	Submission-billing error(s)	M123	Missing-incomplete-invalid name, strength, or dosage of the drug furnished.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
960	Please specify the name of the medication given in this injection.	125	Submission-billing error(s)	M123	Missing-incomplete-invalid name, strength, or dosage of the drug furnished.	409	Medication logs-records (including medication therapy).
962	Writing prescriptions for medication is included in your fee for services.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	454	Procedure code for services rendered.

975	Documentation does not support the necessity for air ambulance. Change miles to reflect ground transport. Do not change your codes. Resubmit as an adjustment.	16	Claim-service lacks information which is needed for adjudication	M22	Missing-incomplete-invalid number of miles traveled.	428	Reason for transport by ambulance
975	Documentation does not support the necessity for air ambulance. Change miles to reflect ground transport. Do not change your codes. Resubmit as an adjustment.	16	Claim-service lacks information which is needed for adjudication	N206	The supporting documentation does not match the claim	428	Reason for transport by ambulance
976	Air ambulance services cut back to ground reimbursement.	150	Payer deems the information submitted does not support this level of service	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	454	Procedure code for services rendered.
977	Service denied. No transport of patient.	115	Procedure postponed-canceled-or delayed.		No Mapping Required	104	Processed according to plan provisions.
978	ALS not documented, please refile as an adjustment with further documentation, or refile as a BLS service.	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes- summary- report- chart.	123	Additional information requested from entity.
978	ALS not documented, please refile as an adjustment with further documentation, or refile as a BLS service.	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes- summary- report- chart.	294	Supporting documentation.
979	ALS not documented, code changed to reflect BLS service.	150	Payment adjusted because the payer deems the information submitted does not support this level of service	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	454	Procedure code for services rendered
980	Miles cut back to the nearest appropriate facility.	117	Transportation is only covered to the closest facility that can provide the necessary care	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	267	Number of miles patient was transported.
980	Miles cut back to the nearest appropriate facility.	117	Transportation is only covered to the closest facility that can provide the necessary care	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	430	Nearest appropriate facility

985	Exceeds monthly legislative limit for prescriptions.	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame	259	Frequency of service.
998	Claim does not require adjustment processing. Resubmit claim with corrections as a new day claim. If POS, reverse and resubmit.	125	Submission-billing error(s)	N59	Alert- Please refer to your provider manual for additional program and provider information	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1038	Claim denied. Refile with the appropriate patient status.	125	Submission-billing error(s)	MA43	Missing-incomplete-invalid patient status.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1050	Electronic provider agreement not on file. Call ECS unit to obtain copy of agreement. No payment made to this prov # for electronic claims until agreement has been approved by DMA.	16	Claim-service lacks information which is needed for adjudication	N51	Electronic interchange agreement not on file for provider-submitter.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1050	Electronic provider agreement not on file. Call ECS unit to obtain copy of agreement. No payment made to this prov # for electronic claims until agreement has been approved by DMA.	16	Claim-service lacks information which is needed for adjudication	N51	Electronic interchange agreement not on file for provider-submitter.	24	Entity not approved as an electronic submitter.
1073	A negative dollar amount was submitted on your claim. Negative values are not permitted. Please correct and resubmit as a new claim.	125	Submission-billing error(s)	M49	Missing-incomplete-invalid value code(s) or amount(s).	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1078	Optical claim form 372-017 is no longer accepted. Please resubmit optical supply charges on the CMS-1500 claim.	125	Submission-billing error(s)	N34	Incorrect claim form-format for this service.	276	UB04-HCFA-1450-1500 claim form

1107	POS - Pharmacy initiated reversal.	B5	Coverage-program guidelines were not met or were exceeded.		No Mapping Required	107	Processed according to contract-plan provisions.
1149	Claim denied, PA is required for rental of apnea monitor.	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	48	Referral-authorization.
1149	Claim denied, PA is required for rental of apnea monitor.	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	84	Service not authorized.
1154	Claim denied pending rate information from DMA. Call HP, Provider Services at 1-800-688-6696.	133	The disposition of this claim-service is pending further review.		No Mapping Required	3	Claim has been adjudicated and is awaiting payment cycle.
1160	Dates of service are later than the last certified date of service. Noncertified days are not reimbursable. For assistance contact FMH at 800-770-3084 ext.3236.	27	Expenses incurred after coverage terminated.	M59	Missing-incomplete-invalid-to-date(s) of service.	187	Date(s) of service.
1170	This procedure or procedure-modifier combination is edited for units, therefore billing a span of days is not allowed. Please bill each date of service on a separate detail	125	Submission-billing error(s)	M53	Missing-incomplete-invalid days or units of service.	258	Days-units for procedure-revenue code.
1170	This procedure or procedure-modifier combination is edited for units, therefore billing a span of days is not allowed. Please bill each date of service on a separate detail	125	Submission-billing error(s)	M53	Missing-incomplete-invalid days or units of service.	453	Procedure code modifier(s) for service(s) rendered.

1181	Service not covered by Medicaid for dental or physician providers.	185	The rendering provider is not eligible to perform the service billed. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	N95	This provider type - provider specialty may not bill this service.	91	Entity not eligible-not approved for dates of service.
1182	This CPT code has been reviewed and denied by DMA dental consultant.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N10	Claim-service adjusted based on the findings of a review organization-professional consult-manual adjudication-medical or dental advisor.	89	Entity not eligible for dental benefits for submitted dates of service.
1183	Not all procedures billed are currently covered for dental providers. Claim is under review by DMA. Upon their decision your claim will be resubmitted for you.	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service.	N59	Alert- Please refer to your provider manual for additional program and provider information.	45	Awaiting benefit determination.
1183	Not all procedures billed are currently covered for dental providers. Claim is under review by DMA. Upon their decision your claim will be resubmitted for you.	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service.	N185	Alert- Do not resubmit this claim-service	45	Awaiting benefit determination.
1186	This CPT procedure or procedure- modifier combination is not covered for physicians or dentists.	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing-incomplete-invalid procedure code(s).	453	Procedure Code Modifier(s) for Service(s) Rendered.
1204	CLIA number is either incorrect-missing from the claim or you have billed a test-DOS outside your CLIA certification.	125	Submission-billing error(s)	MA120	Missing-incomplete-invalid CLIA certification number.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

1204	CLIA number is either incorrect-missing from the claim or you have billed a test-DOS outside your CLIA certification.	125	Submission-billing error(s)	MA120	Missing-incomplete-invalid CLIA certification number.	142	Entitys license-certification number.
1204	CLIA number is either incorrect-missing from the claim or you have billed a test-DOS outside your CLIA certification.	125	Submission-billing error(s)	MA120	Missing-incomplete-invalid CLIA certification number.	630	Referring CLIA Number
1206	V diagnosis is not allowed as a principle diagnosis.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing-incomplete-invalid diagnosis or condition.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1206	V diagnosis is not allowed as a principle diagnosis.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing-incomplete-invalid diagnosis or condition.	255	Diagnosis Code
1224	Resubmit claim with special report and operative notes and-or medical records	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N29	Missing documentation-orders-notes-summary-report-chart.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1224	Resubmit claim with special report and operative notes and-or medical records	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N225	Incomplete-invalid documentation-orders-notes-summary-report-chart	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1224	Resubmit claim with special report and operative notes and-or medical records	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N29	Missing documentation-orders-notes-summary-report-chart.	421	Medical review attachment-information for service(s).
1224	Resubmit claim with special report and operative notes and-or medical records	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N225	Incomplete-invalid documentation-orders-notes-summary-report-chart	421	Medical review attachment-information for service(s).

1248	Suture codes exclusively for would repair; not allowed for extractions-surgery sites.	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	258	Days-units for procedure-revenue code.
1271	For the same tooth, payment is limited to 1 time per surface per episode of treatment. connecting surfaces must be billed under 1 procedure code.If necessary, complete an HP adj form.	119	Benefit maximum for this time period or occurrence has been reached.	N188	The approved level of care does not match the procedure code submitted.	259	Frequency of service.
1319	Procedure code without units denied, correct claim and resubmit as a new claim.	151	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	M53	Missing-incomplete-invalid days or units of service.	476	Missing or invalid units of service
1335	Encounter. Provider number is missing. Enter provider number and resubmit.	125	Submission-billing error(s)	N77	Missing-incomplete-invalid designated provider number.	132	Entitys Medicaid provider id. Note- This code requires use of an Entity Code.
1340	Client behavior intervention services not allowed without a mental health or substance abuse diagnosis.	11	The diagnosis is inconsistent with the procedure.	M76	Missing-incomplete-invalid diagnosis or condition.	255	Diagnosis code.
1344	Service not allowed without a mental disorder diagnosis.	11	The diagnosis is inconsistent with the procedure.	M76	Missing-incomplete-invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered

1350	Provider signature not on file. Sign claim and resubmit or complete 'certification for signature on file' form located on DMA's website under provider links, provider forms	16	Claim-service lacks information which is needed for adjudication	MA81	Missing-incomplete-invalid provider-supplier signature	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1350	Provider signature not on file. Sign claim and resubmit or complete 'certification for signature on file' form located on DMA's website under provider links, provider forms	16	Claim-service lacks information which is needed for adjudication	MA81	Missing-incomplete-invalid provider-supplier signature	117	Claim requires signature-on-file indicator.
1350	Provider signature not on file. Sign claim and resubmit or complete 'certification for signature on file' form located on DMA's website under provider links, provider forms	16	Claim-service lacks information which is needed for adjudication	MA81	Missing-incomplete-invalid provider-supplier signature	466	Entities original signature. Note This code requires use of an Entity Code. This change effective 11-1-2011- Entitys Original Signature. Note- This code requires use of an Entity Code.
1351	Provider signature not on file. Sign claim and resubmit or complete 'certification for signature on file' form located on DMA's website under provider links, provider forms	16	Claim-service lacks information which is needed for adjudication	MA81	Missing-incomplete-invalid provider-supplier signature	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1351	Provider signature not on file. Sign claim and resubmit or complete 'certification for signature on file' form located on DMA's website under provider links, provider forms	16	Claim-service lacks information which is needed for adjudication	MA81	Missing-incomplete-invalid provider-supplier signature	117	Claim requires signature-on-file indicator.

1351	Provider signature not on file. Sign claim and resubmit or complete 'certification for signature on file' form located on DMA's website under provider links, provider forms	16	Claim-service lacks information which is needed for adjudication	MA81	Missing-incomplete-invalid provider-supplier signature	466	Entities original signature. Note This code requires use of an Entity Code. This change effective 11-1-2011- Entitys Original Signature. Note- This code requires use of an Entity Code.
1355	PA number or amount billed does not match the CMNPA form. Review, correct and resubmit as a new claim.	197	Precertification-authorization-notification absent.	M62	Missing-incomplete-invalid treatment authorization code.	48	Referral-authorization.
1355	PA number or amount billed does not match the CMNPA form. Review, correct and resubmit as a new claim.	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	48	Referral-authorization.
1355	PA number or amount billed does not match the CMNPA form. Review, correct and resubmit as a new claim.	197	Precertification-authorization-notification absent.	M62	Missing-incomplete-invalid treatment authorization code.	178	Submitted charges.
1355	PA number or amount billed does not match the CMNPA form. Review, correct and resubmit as a new claim.	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	178	Submitted charges.
1358	Medicaid considers this code to be an integral component to the total procedure. Separate reimbursement is not made.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	54	Duplicate of a previously processed claim-line.
1380	Refile claim on paper with itemized breakdown of charges.	16	Claim-service lacks information which is needed for adjudication	N225	Incomplete-invalid documentation-orders- notes-summary- report- chart.	277	Paper claim.

1380	Refile claim on paper with itemized breakdown of charges.	16	Claim-service lacks information which is needed for adjudication	N225	Incomplete-invalid documentation-orders- notes-summary- report- chart.	279	Itemized claim.
1381	Refile claim with itemized breakdown of charges.	A1	Claim-Service denied	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	279	Itemized claim.
1381	Refile claim with itemized breakdown of charges.	A1	Claim-Service denied	N26	Missing-incomplete-invalid itemized bill	279	Itemized claim.
1381	Refile claim with itemized breakdown of charges.	A1	Claim-Service denied	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	481	Claim-submission format is invalid.
1381	Refile claim with itemized breakdown of charges.	A1	Claim-Service denied	N26	Missing-incomplete-invalid itemized bill	481	Claim-submission format is invalid.
1382	Itemized bill does not support charges billed. Please review charges, correct claim, and resubmit for processing.	125	Submission-billing error(s)	M79	Missing-incomplete-invalid charge.	178	Submitted charges.
1382	Itemized bill does not support charges billed. Please review charges, correct claim, and resubmit for processing.	125	Submission-billing error(s)	N152	Missing-incomplete-invalid replacement claim information.	178	Submitted charges.
1382	Itemized bill does not support charges billed. Please review charges, correct claim, and resubmit for processing.	125	Submission-billing error(s)	M79	Missing-incomplete-invalid charge.	279	Itemized claim.

1382	Itemized bill does not support charges billed. Please review charges, correct claim, and resubmit for processing.	125	Submission-billing error(s)	N152	Missing-incomplete-invalid replacement claim information.	279	Itemized claim.
1385	DMA-PCG recovery project, at DMAs request on claims where other insurance was available to pay medical expenses. For questions, call Sue St. John, PCG, 1-800-372-0878.	133	The disposition of this claim-service is pending further review.		No Mapping Required	3	Claim has been adjudicated and is awaiting payment cycle.
1390	Medicare payment information for this detail is not listed on attached medicare voucher.	148	Information from another provider was not provided or was insufficient-incomplete	N4	Missing-incomplete-invalid prior insurance carrier EOB.	286	Other payers Explanation of Benefits-payment information.
1393	PREVIOUS STATE PAYOUT. RESUBMIT CLAIM WITH RA TO DMA, CLAIMS ANALYSIS UNIT, SEE BILLING GUIDEINES	A1	Claim-Service denied	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	104	Processed according to plan provisions (Plan refers to provisions that exist between the Health Plan and the Consumer or Patient)
1395	Please correct your claim by using a more specific hysterectomy procedure code.	125	Submission-billing error(s)	N56	Procedure code billed is not correct-valid for the service billed or the date of service billed.	454	Procedure code for services rendered.
1397	Routine observation room is noncovered.	78	Non-Covered days-Room charge adjustment.	M79	Missing-incomplete-invalid charge.	258	Days-units for procedure-revenue code.
1400	Claim was specially priced according to agreement between the provider and the division of medical assistance.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N45	Payment based on authorized amount.	64	Re-pricing information.
1403	Only one reduction per arch allowed on the same date of service.	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	612	Per Day Limit Amount

1405	Cap respite not allowed same DOS as adult care and TL.	169	Alternate benefit has been provided	N20	Service not payable with other service rendered on the same date.	258	Days-units for procedure-revenue code.
1408	Reflects overpayments for non-authorized ach enhanced care.	198	Precertification-authorization exceeded	N54	Claim information is inconsistent with pre-certified-authorized services.	64	Re-pricing information.
1413	DMA-PCG repayment of recoupment. Claim originally recouped with EOB 1385. For questions, call PCG, 1-800-372-0878.	198	Precertification-authorization exceeded	N45	Payment based on authorized amount.	64	Re-pricing information.
1414	Provider initiated repayment of claim originally recouped with EOB 1385.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N45	Payment based on authorized amount.	64	Re-pricing information.
1416	Exceeds 20 unit per year limitation.	119	Benefit maximum for this time period or occurrence has been reached.	N357	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	259	Frequency of service.
1416	Exceeds 20 unit per year limitation.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum	259	Frequency of service.
1424	Reflects overpayments for ach enhanced care PCS billed at higher level than authorized.	198	Precertification-authorization exceeded	N54	Claim information is inconsistent with pre-certified-authorized services.	64	Re-pricing information.
1449	Related procedures and DHS dental clinic visit not allowed on same DOS	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	258	Days-units for procedure-revenue code.
1450	Reflects overpayments for ach enhanced care PCS billed for non-authorized dates of service.	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	64	Re-pricing information.

1486	Impotence drugs not covered for males under age 25, The physician (or designee) must obtain prior approval.	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	475	Procedure code not valid for patient age.
1539	D1203 is limited to the application of topical fluoride varnish. Medicaid does not cover other topical fluorides as a separate procedure.	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	258	Days-units for procedure-revenue code.
1540	D1203 is limited to the application of topical fluoride varnish. Rebill prophylaxis and fluoride with correct combination procedure code (D1201 or D1205).	125	Submission-billing error(s)	MA66	Missing-incomplete-invalid principal procedure code or date.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1553	REFER to 1998 CPT for HIV viral load codes and refile.	125	Submission-billing error(s)	MA66	Missing-incomplete-invalid principal procedure code or date.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1556	Other diagnosis code 6 must be further subdivided. (the code must have four or five digits)	146	Diagnosis was invalid for the date(s) of service reported.	M81	You are required to code to the highest level of specificity	255	Diagnosis code.
1557	Other diagnosis code 7 must be further subdivided. (the code must have four or five digits)	146	Diagnosis was invalid for the date(s) of service reported.	M81	You are required to code to the highest level of specificity	255	Diagnosis code.
1558	Other diagnosis code 8 must be further subdivided. (the code must have four or five digits)	146	Diagnosis was invalid for the date(s) of service reported.	M81	You are required to code to the highest level of specificity	255	Diagnosis code.

1559	Other diagnosis code 9 must be further subdivided. (the code must have four or five digits)	146	Diagnosis was invalid for the date(s) of service reported.	M81	You are required to code to the highest level of specificity	255	Diagnosis code.
1566	Adjustment cannot be processed. Explanation to follow.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1574	Adjustment of immediate dentures not allowed until six months after receipt of denture per State limit	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	258	Days-units for procedure-revenue code.
1574	Adjustment of immediate dentures not allowed until six months after receipt of denture per State limit	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	454	Procedure code for services rendered.
1579	Adjustment of immediate dentures not allowed until six months after receipt of denture per State limit	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	258	Days-units for procedure-revenue code.
1579	Adjustment of immediate dentures not allowed until six months after receipt of denture per State limit	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	454	Procedure code for services rendered.
1649	Procedure-Modifier not allowed when billed by Area Mental Health Provider for recipients age 000-003 who are not CAP-MR-DD on the DOS billed	177	Patient has not met the required eligibility requirements.	N30	Patient ineligible for this service.	453	Procedure Code Modifier(s) for Service(s) Rendered.
1649	Procedure-Modifier not allowed when billed by Area Mental Health Provider for recipients age 000-003 who are not CAP-MR-DD on the DOS billed	177	Patient has not met the required eligibility requirements.	N216	Patient is not enrolled in this portion of our benefit package	453	Procedure Code Modifier(s) for Service(s) Rendered

1649	Procedure-Modifier not allowed when billed by Area Mental Health Provider for recipients age 000-003 who are not CAP-MR-DD on the DOS billed	177	Patient has not met the required eligibility requirements.	N30	Patient ineligible for this service.	475	Procedure code not valid for patient age
1649	Procedure-Modifier not allowed when billed by Area Mental Health Provider for recipients age 000-003 who are not CAP-MR-DD on the DOS billed	177	Patient has not met the required eligibility requirements.	N216	Patient is not enrolled in this portion of our benefit package	475	Procedure code not valid for patient age
1679	Medicaid payments suspended for non-compliance of false claim act. Please submit attestation letter.	B5	Coverage-program guidelines were not met or were exceeded.	N59	Alert- Please refer to your provider manual for additional program and provider information	585	Denied Charge or Non-covered Charge.
1679	Medicaid payments suspended for non-compliance of false claim act. Please submit attestation letter.	B5	Coverage-program guidelines were not met or were exceeded.	N59	Alert- Please refer to your provider manual for additional program and provider information	615	Policy Compliance Code.
1692	Signatures are missing/illegible. Check or include all attachments requiring signatures with legible copies & submit to DMA Program Integrity home care review.	A1	Claim-Service denied	N29	Missing documentation-orders-notes-summary-report-chart.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1692	Signatures are missing/illegible. Check or include all attachments requiring signatures with legible copies & submit to DMA Program Integrity home care review.	A1	Claim-Service denied	N35	Program integrity-utilization review decision.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1692	Signatures are missing/illegible. Check or include all attachments requiring signatures with legible copies & submit to DMA Program Integrity home care review.	A1	Claim-Service denied	N205	Information provided was illegible.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

1692	Signatures are missing/illegible. Check or include all attachments requiring signatures with legible copies & submit to DMA Program Integrity home care review.	A1	Claim-Service denied	N29	Missing documentation-orders-notes-summary-report-chart.	294	Supporting documentation
1692	Signatures are missing/illegible. Check or include all attachments requiring signatures with legible copies & submit to DMA Program Integrity home care review.	A1	Claim-Service denied	N35	Program integrity-utilization review decision.	294	Supporting documentation
1692	Signatures are missing/illegible. Check or include all attachments requiring signatures with legible copies & submit to DMA Program Integrity home care review.	A1	Claim-Service denied	N205	Information provided was illegible.	294	Supporting documentation
1693	Required certificates missing/invalid. Submit to DMA Program Integrity home care review w/home aide info., RN/PCS Cert., licenses of staff rendering svc. Or appropriate documents	A1	Claim-Service denied	N29	Missing documentation-orders-notes-summary-report-chart.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1693	Required certificates missing/invalid. Submit to DMA Program Integrity home care review w/home aide info., RN/PCS Cert., licenses of staff rendering svc. Or appropriate documents	A1	Claim-Service denied	N35	Program integrity-utilization review decision.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

1693	Required certificates missing/invalid. Submit to DMA Program Integrity home care review w/home aide info., RN/PCS Cert., licenses of staff rendering svc. Or appropriate documents	A1	Claim-Service denied	N225	Incomplete-invalid documentation-orders-notes-summary-report-chart	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1693	Required certificates missing/invalid. Submit to DMA Program Integrity home care review w/home aide info., RN/PCS Cert., licenses of staff rendering svc. Or appropriate documents	A1	Claim-Service denied	N29	Missing documentation-orders-notes-summary-report-chart.	294	Supporting documentation
1693	Required certificates missing/invalid. Submit to DMA Program Integrity home care review w/home aide info., RN/PCS Cert., licenses of staff rendering svc. Or appropriate documents	A1	Claim-Service denied	N35	Program integrity-utilization review decision.	294	Supporting documentation
1693	Required certificates missing/invalid. Submit to DMA Program Integrity home care review w/home aide info., RN/PCS Cert., licenses of staff rendering svc. Or appropriate documents	A1	Claim-Service denied	N29	Missing documentation-orders-notes-summary-report-chart.	294	Supporting documentation
1694	Aide's time/task sheet (work log) is missing or information is incomplete/illegible. Submit a legible copy and/or completed log if it exists.	A1	Claim-Service denied	N205	Information provided was illegible.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

1694	Aide's time/task sheet (work log) is missing or information is incomplete/illegible. Submit a legible copy and/or completed log if it exists.	A1	Claim-Service denied	N225	Incomplete-invalid documentation-orders-notes-summary-report-chart	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1694	Aide's time/task sheet (work log) is missing or information is incomplete/illegible. Submit a legible copy and/or completed log if it exists.	A1	Claim-Service denied	N205	Information provided was illegible.	294	Supporting documentation
1694	Aide's time/task sheet (work log) is missing or information is incomplete/illegible. Submit a legible copy and/or completed log if it exists.	A1	Claim-Service denied	N225	Incomplete-invalid documentation-orders-notes-summary-report-chart	294	Supporting documentation
1695	Documentation submitted does not support medicaid coverage policy requirements. Submit claim to DMA Program Integrity Home Care Review with necessary documentation.	B5	Coverage-program guidelines were not met or were exceeded.	N35	Program integrity-utilization review decision	294	Supporting documentation
1726	Payment has been reduced to the same total reimbursement as the intraoral complete series.	B10	Allowed amount has been reduced because a component of the basic procedure-test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure-test.	N10	Payment based on the findings of a review organization-professional consult-manual adjudication-medical or dental advisor.	66	Payment reflects usual and customary charges.
1726	Payment has been reduced to the same total reimbursement as the intraoral complete series.	B10	Allowed amount has been reduced because a component of the basic procedure-test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure-test.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	66	Payment reflects usual and customary charges.

1726	Payment has been reduced to the same total reimbursement as the intraoral complete series.	B10	Allowed amount has been reduced because a component of the basic procedure-test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure-test.	N10	Payment based on the findings of a review organization-professional consult-manual adjudication-medical or dental advisor.	239	Dental information.
1726	Payment has been reduced to the same total reimbursement as the intraoral complete series.	B10	Allowed amount has been reduced because a component of the basic procedure-test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure-test.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	239	Dental information.
1729	Oral evaluation must be billed with topical fluoride varnish application.	107	The related or qualifying claim-service was not identified on this claim. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	N19	Procedure code incidental to primary procedure.	490	Other Procedure Code for Service(s) Rendered
1729	Oral evaluation must be billed with topical fluoride varnish application.	107	The related or qualifying claim-service was not identified on this claim. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	N161	This drug-service-supply is covered only when the associated service is covered.	490	Other Procedure Code for Service(s) Rendered
1743	REIMBURSEMENT FOR RESORTATIVE PROCEDURE CODE INCLUDES ALL NECESSARY BASES AND LINERS	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N381	Consult our contractual agreement for restrictions-billing information related to these charges.	454	Procedure code for services rendered.
1746	The core (billing) and service level (attending) provider type and specialty combination are not valid for the service billed	A1	Claim-Service denied	N95	This provider type - provider specialty may not bill this service	454	Procedure code for services rendered

1752	Repeat billing of the same quadrant for periodontal scaling and root planing not allowed in this time frame	18	Exact duplicate claim-service	M86	Service denied because payment already made for same-similar procedure within set time frame.	259	Frequency of service.
1755	Drug/Implant must be billed with the appropriate administration code	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing-incomplete-invalid procedure code(s).	465	Principal Procedure Code for Service(s) Rendered
1770	Invalid procedure-modifier-diagnosis code combination for Health Check or Family Planning services. Correct and resubmit as a new claim.	4	The procedure code is inconsistent with the modifier or a required modifier is missing. Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present		No Mapping Required	255	Diagnosis code.
1772	Maximum allowable for Health Department Immunization Administration has already been paid.	B13	Previously paid. Payment for this claim-service may have been provided in a previous payment		No Mapping Required	483	Maximum coverage amount met or exceeded for benefit period.
1779	Newborn Assessment limited to once per lifetime	149	Lifetime benefit maximum has been reached for this service-benefit category	N117	This service is paid only once in a patients lifetime.	259	Frequency of service.
1782	Adjustment due to refund from provider	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement		No Mapping Required	1	For more detailed information, see remittance advice.
1794	Two quadrant periodontal scaling and root planing allowed per date of service unless treatment is rendered in hospital or ambulatory surgical center	119	Benefit maximum for this time period or occurrence has been reached	M86	Service denied because payment already made for same-similar procedure within set time frame.	259	Frequency of service.

1794	Two quadrant periodontal scaling and root planing allowed per date of service unless treatment is rendered in hospital or ambulatory surgical center	119	Benefit maximum for this time period or occurrence has been reached	M86	Service denied because payment already made for same-similar procedure within set time frame.	612	Per Day Limit Amount
1797	Services limited to those provided during inpatient hospital stay.	58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	M2	Not paid separately when the patient is an inpatient.	249	Place of service.
1797	Services limited to those provided during inpatient hospital stay.	58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	M2	Not paid separately when the patient is an inpatient.	250	Type of service.
1799	Recipient is not eligible for medicaid claims payment due to current living arrangement.	32	Our records indicate that this dependent is not an eligible dependent as defined.	N424	Patient does not reside in the geographic area required for this type of payment.	109	Entity not eligible. Note- This code requires use of an Entity Code.
1809	Pharmacy management fee is reimbursed only through system generated claims	A1	Claim-Service denied	N185	Alert- Do not resubmit this claim-service	585	Denied Charge or Non-covered Charge
1810	Your claim is denied. Submit all required PCS documentation with your claim to DMA Program Integrity Home Care	A1	Claim-Service denied	N29	Missing documentation-orders-notes-summary-report-chart.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1810	Your claim is denied. Submit all required PCS documentation with your claim to DMA Program Integrity Home Care	A1	Claim-Service denied	N225	Incomplete-invalid documentation-orders-notes-summary-report-chart.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

1810	Your claim is denied. Submit all required PCS documentation with your claim to DMA Program Integrity Home Care	A1	Claim-Service denied	N29	Missing documentation-orders-notes-summary-report-chart.	294	Supporting documentation
1810	Your claim is denied. Submit all required PCS documentation with your claim to DMA Program Integrity Home Care	A1	Claim-Service denied	N225	Incomplete-invalid documentation-orders-notes-summary-report-chart.	294	Supporting documentation
1812	Payment denied. Attending provider eligibility terminated for failure to re-credential provider enrollment. Contact CSC at 866-844-1113 for assistance in addressing this denial	A1	Claim-Service denied	N257	Missing-incomplete-invalid billing provider-supplier primary identifier	562	Entity's National Provider Identifier (NPI). Note- This code requires use of an Entity Code.
1813	Payment denied for failure to re-credential individual attending provider enrollment. Contact CSC at 866-844-1113 for assistance in addressing this denial	A1	Claim-Service denied	N253	Missing-incomplete-invalid attending provider primary identifier.	562	Entity's National Provider Identifier (NPI). Note- This code requires use of an Entity Code.
1814	Payment denied. Billing provider eligibility terminated for failure to re-credential provider enrollment. Contact CSC at 866-844-1113 for assistance in addressing this denial	A1	Claim-Service denied	N257	Missing-incomplete-invalid billing provider-supplier primary identifier	562	Entity's National Provider Identifier (NPI). Note- This code requires use of an Entity Code.
1815	Payment denied for failure to re-credential billing provider enrollment. Contact CSC at 866-844-1113 for assistance in addressing this denial	A1	Claim-Service denied	N253	Missing-incomplete-invalid attending provider primary identifier.	562	Entity's National Provider Identifier (NPI). Note- This code requires use of an Entity Code.

1893	Related therapeutic parental drugs not allowed same day.	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	258	Days-units for procedure-revenue code.
1895	Claim denied because it is subject to transfer of asset penalties.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement		No Mapping Required	1	For more detailed information, see remittance advice.
1896	Claim denied and cannot be paid until a transfer of assets assessment has been completed. Please contact the patient.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement		No Mapping Required	1	For more detailed information, see remittance advice.
1897	Claim pended awaiting transfer of asset assessment by county DSS.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement		No Mapping Required	1	For more detailed information, see remittance advice.
1997	DENTAL RADIOGRAPH PROCEDURE LIMITED TO SIX PER FIVE YEAR PERIOD	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	259	Frequency of service.
1997	DENTAL RADIOGRAPH PROCEDURE LIMITED TO SIX PER FIVE YEAR PERIOD	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.
1997	DENTAL RADIOGRAPH PROCEDURE LIMITED TO SIX PER FIVE YEAR PERIOD	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	297	Medical notes-report.

1997	DENTAL RADIOGRAPH PROCEDURE LIMITED TO SIX PER FIVE YEAR PERIOD	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	297	Medical notes-report.
2040	Procedure not allowed on the same date of service as an extraction for the same tooth	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2040	Procedure not allowed on the same date of service as an extraction for the same tooth	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.
2050	Header information submitted without claim detail. Enter detail information and resubmit.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2079	This attending provider is not allowed for the procedure billed.	185	The rendering provider is not eligible to perform the service	N253	Missing-incomplete-invalid attending provider primary	25	Entity not approved.

2123	This case has exceeded the initial 36 months approved. Submit an orthodontic extension request. Document reason and anticipated completion date to HP- Prior Approval unit.	119	Benefit maximum for this time period or occurrence has been reached.	N54	Claim information is inconsistent with pre-certified-authorized services.	259	Frequency of service.
2123	This case has exceeded the initial 36 months approved. Submit an orthodontic extension request. Document reason and anticipated completion date to HP- Prior Approval unit.	119	Benefit maximum for this time period or occurrence has been reached.	N54	Claim information is inconsistent with pre-certified-authorized services.	294	Supporting documentation.
2123	This case has exceeded the initial 36 months approved. Submit an orthodontic extension request. Document reason and anticipated completion date to HP- Prior Approval unit.	119	Benefit maximum for this time period or occurrence has been reached.	N54	Claim information is inconsistent with pre-certified-authorized services.	353	Orthodontics treatment plan.
2146	Medicaid procedure code or procedure rate cannot be determined for crossover claim.	A1	Claim-Service denied	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service-provider.	454	Procedure code for services rendered.
2148	RECIPIENT ENROLLED IN MEDICARE AND ANOTHER THIRD PARTY INSURANCE. REBILL ON PAPER TOTALING INSURANCE AMOUNTS IN PROPER FILED ON CLAIM FORM AND ATTACH BOTH VOUCHERS	148	Information from another provider was not provided or was insufficient-incomplete	MA92	Missing-incomplete-invalid plan information for other insurance.	279	Itemized claim.

2148	RECIPIENT ENROLLED IN MEDICARE AND ANOTHER THIRD PARTY INSURANCE. REBILL ON PAPER TOTALING INSURANCE AMOUNTS IN PROPER FILED ON CLAIM FORM AND ATTACH BOTH VOUCHERS	148	Information from another provider was not provided or was insufficient-incomplete	N131	Total payments under multiple contracts can not exceed the allowance for this service.	279	Itemized claim.
2148	RECIPIENT ENROLLED IN MEDICARE AND ANOTHER THIRD PARTY INSURANCE. REBILL ON PAPER TOTALING INSURANCE AMOUNTS IN PROPER FILED ON CLAIM FORM AND ATTACH BOTH VOUCHERS	148	Information from another provider was not provided or was insufficient-incomplete	MA92	Missing-incomplete-invalid plan information for other insurance.	286	Other payer's Explanation of Benefits (EOB).
2148	RECIPIENT ENROLLED IN MEDICARE AND ANOTHER THIRD PARTY INSURANCE. REBILL ON PAPER TOTALING INSURANCE AMOUNTS IN PROPER FILED ON CLAIM FORM AND ATTACH BOTH VOUCHERS	148	Information from another provider was not provided or was insufficient-incomplete	N131	Total payments under multiple contracts can not exceed the allowance for this service.	286	Other payer's Explanation of Benefits (EOB).
2148	RECIPIENT ENROLLED IN MEDICARE AND ANOTHER THIRD PARTY INSURANCE. REBILL ON PAPER TOTALING INSURANCE AMOUNTS IN PROPER FILED ON CLAIM FORM AND ATTACH BOTH VOUCHERS	148	Information from another provider was not provided or was insufficient-incomplete	MA92	Missing-incomplete-invalid plan information for other insurance.	400	Claim is out of balance.

2148	RECIPIENT ENROLLED IN MEDICARE AND ANOTHER THIRD PARTY INSURANCE. REBILL ON PAPER TOTALING INSURANCE AMOUNTS IN PROPER FILED ON CLAIM FORM AND ATTACH BOTH VOUCHERS	148	Information from another provider was not provided or was insufficient-incomplete	N131	Total payments under multiple contracts can not exceed the allowance for this service.	400	Claim is out of balance.
2149	PREVIOUS INSURANCE PAYMENT AMOUNTS DO NOT EQUAL TOTAL AMOUNT ENTERED ON CLAIM FORM. CORRECT CLAIM AND RESUBMIT AS A NEW DAY CLAIM	148	Information from another provider was not provided or was insufficient-incomplete	MA92	Missing-incomplete-invalid plan information for other insurance	279	Itemized claim.
2149	PREVIOUS INSURANCE PAYMENT AMOUNTS DO NOT EQUAL TOTAL AMOUNT ENTERED ON CLAIM FORM. CORRECT CLAIM AND RESUBMIT AS A NEW DAY CLAIM	148	Information from another provider was not provided or was insufficient-incomplete	MA92	Missing-incomplete-invalid plan information for other insurance	286	Other payer's Explanation of Benefits (EOB).
2158	Claim denied due to bad address on provider file.	125	Submission-billing error(s)	N258	Missing-incomplete-invalid billing provider-supplier address.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2158	Claim denied due to bad address on provider file.	125	Submission-billing error(s)	N258	Missing-incomplete-invalid billing provider-supplier address.	126	Entity's address.
2177	MEDICARE VOUCHER INDICATES 100% OF MEDICARE ALLOWED AMOUNT WAS APPLIED TOWARD RECIPIENT'S DEDUCTIBLE. CLAIM INDICATES MEDICARE PAYMENT AS THIRD PARTY AMOUNT. CORRECT AND RESUBMIT	129	Prior processing information appears incorrect.	N48	Claim information does not agree with information received from other insurance carrier.	286	Other payer's Explanation of Benefits (EOB).

2200	Denied for pre-payment review. Contact DMA at 919-647-8000	133	The disposition of this claim-service is pending further review.		No Mapping Required	1	For more detailed information, see remittance advice.
2201	Procedure code billed requires prior approval from med solutions inc. at 800-575-4517, option 1	125	Submission-billing error(s)	N175	Missing review organization approval.	40	Waiting for final approval.
2208	The revenue code billed requires procedure code to be attached.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2208	The revenue code billed requires procedure code to be attached.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	454	Procedure code for services rendered.
2209	Claim Recouped. Resubmit claim with U2 modifier if recipient was inpatient, in observation, in ER or referred from emergency department or urgent care.	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. This change to be effective 7-1-2010- The procedure code is inconsistent with the modifier used or a	N13	Payment based on professional technical component modifier(s).	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
					Payment based on professional		

2210	Detail recouped. Resubmit detail with U2 modifier if recipient was inpatient, in observation, in ER or referred from emergency department or urgent care.	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. This change to be effective 7-1-2010- The procedure code is inconsistent with the modifier used or a required modifier is missing.	N13	Payment based on professional technical component modifier(s).	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2210	Detail recouped. Resubmit detail with U2 modifier if recipient was inpatient, in observation, in ER or referred from emergency department or urgent care.	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. This change to be effective 7-1-2010- The procedure code is inconsistent with the modifier used or a required modifier is missing.	N13	Payment based on professional technical component modifier(s).	453	Procedure Code Modifier(s) for Service(s) Rendered
2222	No documentation on file with CCME. Please call CCME at 1-800-228-3365	16	Claim-service lacks information which is needed for adjudication	N206	The supporting documentation does not match the claim	187	Date(s) of service.
2222	No documentation on file with CCME. Please call CCME at 1-800-228-3365	16	Claim-service lacks information which is needed for adjudication	N206	The supporting documentation does not match the claim	454	Procedure code for services rendered.
2230	Out of State service not allowed without PA or documentation of imminent life threatening-emergency condition on DOS.	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	431	Provide condition - functional status at time of service
	zero dollars reflecting penalty						

2242	Refund applied to outstanding principal, penalty, and interest balances (refer to write-off eob). 1099 credited for return of Medicaid payments.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).		No Mapping Required	1	For more detailed information, see remittance advice.
2243	Transfer of principal system adjustment to active provider with same Tax ID. Original provider is no longer active.	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if presentNote- Refer to the 835 Healthcare Policy Identification		No Mapping Required	1	For more detailed information, see remittance advice.
2244	Transfer of principal manual adjustment to active provider with same Tax ID original.	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of		No Mapping Required	1	For more detailed information, see remittance advice.

2246	Transfer of penalty from manual adjustment to active provider with same Tax ID. Original provider is no longer active.	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if presentNote- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		No Mapping Required	1	For more detailed information, see remittance advice.
2247	Transfer of interest from system adjustment to active provider with same Tax ID. Original provider is no longer active.	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if presentNote- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		No Mapping Required	1	For more detailed information, see remittance advice.
2248	Transfer of interest from manual adjustment to active provider with same Tax ID. Original provider is no longer active.	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if presentNote- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		No Mapping Required	1	For more detailed information, see remittance advice.

2249	Adj, write – off due to transfer of outstanding balance No effect on claims payment summary items.(Columns A-I)	102	Major Medical Adjustment.		No Mapping Required	104	Processed according to plan provisions.
2249	Adj, write – off due to transfer of outstanding balance No effect on claims payment summary items.(Columns A-I)	102	Major Medical Adjustment.		No Mapping Required	519	Adjustment Amount.
2249	Adj, write – off due to transfer of outstanding balance No effect on claims payment summary items.(Columns A-I)	102	Major Medical Adjustment.		No Mapping Required	521	Adjustment Reason Code.
2250	Adj write- off generated due to provider refund. No effect on claims.(Columns A-I)	102	Major Medical Adjustment.		No Mapping Required	104	Processed according to plan provisions.
2250	Adj write- off generated due to provider refund. No effect on claims.(Columns A-I)	102	Major Medical Adjustment.		No Mapping Required	519	Adjustment Amount.
2250	Adj write- off generated due to provider refund. No effect on claims.(Columns A-I)	102	Major Medical Adjustment.		No Mapping Required	521	Adjustment Reason Code.
2251	Adj. Write- off to reverse penalty assessments generated.	102	Major Medical Adjustment.		No Mapping Required	104	Processed according to plan provisions.
2251	Adj. Write- off to reverse penalty assessments generated.	102	Major Medical Adjustment.		No Mapping Required	519	Adjustment Amount.
2251	Adj. Write- off to reverse penalty assessments generated.	102	Major Medical Adjustment.		No Mapping Required	521	Adjustment Reason Code.
2252	Adj. Write – off to reverse interest assessments generated.	102	Major Medical Adjustment.		No Mapping Required	104	Processed according to plan provisions.
2252	Adj. Write – off to reverse interest assessments generated.	102	Major Medical Adjustment.		No Mapping Required	519	Adjustment Amount.

2252	Adj. Write – off to reverse interest assessments generated.	102	Major Medical Adjustment.		No Mapping Required	521	Adjustment Reason Code.
2253	Adj. Bad – debt write – off. No effect on claims payment summary items.(Columns A-I)	102	Major Medical Adjustment.		No Mapping Required	104	Processed according to plan provisions.
2253	Adj. Bad – debt write – off. No effect on claims payment summary items.(Columns A-I)	102	Major Medical Adjustment.		No Mapping Required	519	Adjustment Amount.
2253	Adj. Bad – debt write – off. No effect on claims payment summary items.(Columns A-I)	102	Major Medical Adjustment.		No Mapping Required	521	Adjustment Reason Code.
2254	One-time penalty adj assessed systematically. assessment of 10% for aged(>30 days)bal.due(prin only). claims dollars are applied to outstanding penalty adj bal. from oldest to newest.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).		No Mapping Required	1	For more detailed information, see remittance advice.
2255	One-time penalty adj assessed manually. assess of 10% for aged(>30 days)bal.due(prin only). claims dollars are applied to outstanding penalty adj bal. from oldest to newest.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).		No Mapping Required	1	For more detailed information, see remittance advice.
2256	Interest assessed systematically on adj bal. Due (principal, penalty,& interest) aged >30 days. Claims dollars are applied to outstanding interest adj balances from oldest to newest.	85	Patient Interest Adjustment		No Mapping Required	1	For more detailed information, see remittance advice.

2257	Interest assessed systematically on adj bal. Due (principal, penalty, & interest) aged >30 days. Claims dollars are applied to outstanding interest adj balances from oldest to newest.	85	Patient Interest Adjustment		No Mapping Required	1	For more detailed information, see remittance advice.
2262	Penalty payout.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).		No Mapping Required	1	For more detailed information, see remittance advice.
2263	Interest payout.	85	Patient Interest Adjustment		No Mapping Required	1	For more detailed information, see remittance advice.
2281	Recipient in PACE program for all inclusive care of elderly. Recipient's card indicates PACE provider responsible for care. Fee for service care not covered outside of PACE	177	Patient has not met the required eligibility requirements.		No Mapping Required	84	Service not authorized.
2528	Claims for this time period are being paid through settlement. Please contact DMA rate setting	119	Benefit maximum for this time period or occurrence has been reached	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	104	Processed according to plan provisions.
2600	Service and-or place of service not covered under the Family Planning Waiver	5	The procedure code-bill type is inconsistent with the place of service.	M77	Missing-incomplete-invalid place of service.	228	Type of bill for UB claim.
2600	Service and-or place of service not covered under the Family Planning Waiver	5	The procedure code-bill type is inconsistent with the place of service.	M77	Missing-incomplete-invalid place of service.	249	Place of service.
2601	Procedure not covered under the Family Planning Waiver	A1	Claim-Service denied	M51	Missing-incomplete-invalid procedure code(s).	454	Procedure code for services rendered.
2751	DME service recouped. Not allowed same day as service rendered for CAP provider.	A1	Claim-Service denied	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure code modifier(s) for service(s) rendered.

2751	DME service recouped. Not allowed same day as service rendered for CAP provider.	A1	Claim-Service denied	M86	Service denied because payment already made for same/similar procedure within set timeframe.	453	Procedure code modifier(s) for service(s) rendered.
2751	DME service recouped. Not allowed same day as service rendered for CAP provider.	A1	Claim-Service denied	N20	Service not payable with other service rendered on the same date.	453	Procedure code modifier(s) for service(s) rendered.
2901	Denied due to inactive EFT status	A1	Claim-Service denied	N24	Missing-incomplete-invalid Electronic Funds Transfer (EFT) banking information.	585	Denied Charge or Non-covered Charge
2905	POS - version-release number invalid .	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2930	POS - claim or reversal greater than 365 days old. Refile claim (paper) with proper documentation for time limit override.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2982	DAW 1 not allowed on this drug	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N59	Alert- Please refer to your provider manual for additional program and provider information	1	For more detailed information, see remittance advice.
2982	DAW 1 not allowed on this drug	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N59	Alert- Please refer to your provider manual for additional program and provider information	217	Drug name, strength and dosage form.
2983	DAW 5 not allowed on this drug	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N59	Alert- Please refer to your provider manual for additional program and provider information	1	For more detailed information, see remittance advice.

2983	DAW 5 not allowed on this drug	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N59	Alert- Please refer to your provider manual for additional program and provider information	217	Drug name, strength and dosage form.
2984	DAW 7 not allowed on this drug	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N59	Alert- Please refer to your provider manual for additional program and provider information	1	For more detailed information, see remittance advice.
2984	DAW 7 not allowed on this drug	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N59	Alert- Please refer to your provider manual for additional program and provider information	217	Drug name, strength and dosage form.
2986	Detail line recouped, per provider request.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA91	This determination is the result of the appeal you filed	104	Processed according to plan provisions.
2990	CISA claims must be billed with a valid referring provider number.	52	The referring-prescribing-rendering provider is not eligible to refer-prescribe-order-perform the service billed.	N286	Missing-incomplete-invalid referring provider primary identifier.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2990	CISA claims must be billed with a valid referring provider number.	52	The referring-prescribing-rendering provider is not eligible to refer-prescribe-order-perform the service billed.	N286	Missing-incomplete-invalid referring provider primary identifier.	132	Entitys Medicaid provider id. Note- This code requires use of an Entity Code.
2991	RESUBMIT AS AN ADJUSTMENT WITH THE MEDICARE VOUCHER OR SUBMIT A PROFESSIONAL 837 TRANSACTION WITH THE MEDICARE DATA ELEMENTS POPULATED.	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	116	Claim submitted to incorrect payer.

2991	RESUBMIT AS AN ADJUSTMENT WITH THE MEDICARE VOUCHER OR SUBMIT A PROFESSIONAL 837 TRANSACTION WITH THE MEDICARE DATA ELEMENTS POPULATED.	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	286	Other payer's Explanation of Benefits (EOB).
2992	RESUBMIT AS ADJUSTMENT WITH MEDICARE VOUCHER OR SUBMIT A PROFESSIONAL 837 TRANSACTION WITH MEDICARE DATA ELEMENTS POPULATED. TPL AMOUNTS SHOULD NOT INCLUDE MEDICARE PAYMENTS.	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	286	Other payer's Explanation of Benefits (EOB).
2992	RESUBMIT AS ADJUSTMENT WITH MEDICARE VOUCHER OR SUBMIT A PROFESSIONAL 837 TRANSACTION WITH MEDICARE DATA ELEMENTS POPULATED. TPL AMOUNTS SHOULD NOT INCLUDE MEDICARE PAYMENTS.	22	This care may be covered by another payer per coordination of benefits.	N82	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.	286	Other payer's Explanation of Benefits (EOB).
2992	RESUBMIT AS ADJUSTMENT WITH MEDICARE VOUCHER OR SUBMIT A PROFESSIONAL 837 TRANSACTION WITH MEDICARE DATA ELEMENTS POPULATED. TPL AMOUNTS SHOULD NOT INCLUDE MEDICARE PAYMENTS.	22	This care may be covered by another payer per coordination of benefits.	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	286	Other payer's Explanation of Benefits (EOB).

2992	RESUBMIT AS ADJUSTMENT WITH MEDICARE VOUCHER OR SUBMIT A PROFESSIONAL 837 TRANSACTION WITH MEDICARE DATA ELEMENTS POPULATED. TPL AMOUNTS SHOULD NOT INCLUDE MEDICARE PAYMENTS.	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	655	Total Medicare Paid Amount
2992	RESUBMIT AS ADJUSTMENT WITH MEDICARE VOUCHER OR SUBMIT A PROFESSIONAL 837 TRANSACTION WITH MEDICARE DATA ELEMENTS POPULATED. TPL AMOUNTS SHOULD NOT INCLUDE MEDICARE PAYMENTS.	22	This care may be covered by another payer per coordination of benefits.	N82	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.	655	Total Medicare Paid Amount
2992	RESUBMIT AS ADJUSTMENT WITH MEDICARE VOUCHER OR SUBMIT A PROFESSIONAL 837 TRANSACTION WITH MEDICARE DATA ELEMENTS POPULATED. TPL AMOUNTS SHOULD NOT INCLUDE MEDICARE PAYMENTS.	22	This care may be covered by another payer per coordination of benefits.	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	655	Total Medicare Paid Amount
2993	Claim with DOS between 10-1-2002 and 9-5-2004 must be filed as Medicare TPL. Clams with DOS 9-6-2004 and after must be filed as crossovers. Split DOS and re-file claims	125	Submission-billing error(s)	M51	Missing-incomplete-invalid, procedure code(s) and-or dates.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

2993	Claim with DOS between 10-1-2002 and 9-5-2004 must be filed as Medicare TPL. Clams with DOS 9-6-2004 and after must be filed as crossovers. Split DOS and re-file claims	125	Submission-billing error(s)	N61	Rebill services on separate claims.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2993	Claim with DOS between 10-1-2002 and 9-5-2004 must be filed as Medicare TPL. Clams with DOS 9-6-2004 and after must be filed as crossovers. Split DOS and re-file claims	125	Submission-billing error(s)	N301	Missing-incomplete-invalid procedure date(s).	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2993	Claim with DOS between 10-1-2002 and 9-5-2004 must be filed as Medicare TPL. Clams with DOS 9-6-2004 and after must be filed as crossovers. Split DOS and re-file claims	125	Submission-billing error(s)	N61	Rebill services on separate claims.	72	Claim contains split payment
2993	Claim with DOS between 10-1-2002 and 9-5-2004 must be filed as Medicare TPL. Clams with DOS 9-6-2004 and after must be filed as crossovers. Split DOS and re-file claims	125	Submission-billing error(s)	N61	Rebill services on separate claims.	72	Claim contains split payment
2993	Claim with DOS between 10-1-2002 and 9-5-2004 must be filed as Medicare TPL. Clams with DOS 9-6-2004 and after must be filed as crossovers. Split DOS and re-file claims	125	Submission-billing error(s)	N61	Rebill services on separate claims.	72	Claim contains split payment
2993	Claim with DOS between 10-1-2002 and 9-5-2004 must be filed as Medicare TPL. Clams with DOS 9-6-2004 and after must be filed as crossovers. Split DOS and re-file claims	125	Submission-billing error(s)	N301	Missing-incomplete-invalid procedure date(s).	481	Claim-submission format is invalid.

2993	Claim with DOS between 10-1-2002 and 9-5-2004 must be filed as Medicare TPL. Clams with DOS 9-6-2004 and after must be filed as crossovers. Split DOS and re-file claims	125	Submission-billing error(s)	N301	Missing-incomplete-invalid procedure date(s).	481	Claim-submission format is invalid.
2993	Claim with DOS between 10-1-2002 and 9-5-2004 must be filed as Medicare TPL. Clams with DOS 9-6-2004 and after must be filed as crossovers. Split DOS and re-file claims	125	Submission-billing error(s)	N301	Missing-incomplete-invalid procedure date(s).	481	Claim-submission format is invalid.
2994	Effective 9-6-2004, NC Medicaid no longer processes professional Medicare TPL Claims. From DOS indicates claim must be submitted as a Medicare Part B claim.	125	Submission-billing error(s)	M51	Missing-incomplete-invalid, procedure code(s).	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2994	Effective 9-6-2004, NC Medicaid no longer processes professional Medicare TPL Claims. From DOS indicates claim must be submitted as a Medicare Part B claim.	125	Submission-billing error(s)	M51	Missing-incomplete-invalid, procedure code(s).	72	Claim contains split payment.
2994	Effective 9-6-2004, NC Medicaid no longer processes professional Medicare TPL Claims. From DOS indicates claim must be submitted as a Medicare Part B claim.	125	Submission-billing error(s)	M51	Missing-incomplete-invalid, procedure code(s).	481	Claim-submission format is invalid.
2994	Effective 9-6-2004, NC Medicaid no longer processes professional Medicare TPL Claims. From DOS indicates claim must be submitted as a Medicare Part B claim.	125	Submission-billing error(s)	N61	Rebill services on separate claims.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

2994	Effective 9-6-2004, NC Medicaid no longer processes professional Medicare TPL Claims. From DOS indicates claim must be submitted as a Medicare Part B claim.	125	Submission-billing error(s)	N301	Missing-incomplete-invalid procedure date(s).	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2995	Co-insurance and deductible payment based on DMA Part B reimbursement schedule.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N45	Payment based on authorized amount.	107	Processed according to contract-plan provisions
2995	Co-insurance and deductible payment based on DMA Part B reimbursement schedule.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions
2998	Resubmit claim with appropriate directed anesthesia modifier	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		No Mapping Required	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2998	Resubmit claim with appropriate directed anesthesia modifier	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		No Mapping Required	453	Procedure Code Modifier(s) for Service(s) Rendered
3000	Claim paid based on the Medicare HMO Cost Sharing Amount	23	The impact of prior payer(s) adjudication including payments and-or adjustments		No Mapping Required	65	Claim-line has been paid.
3091	Billing NPI and/or billing taxonomy is missing. Attending NPO and/or attending taxonomy, when required is missing	206	National Provider Identifier - missing	N251	Missing-incomplete-invalid attending provider taxonomy.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3091	Billing NPI and/or billing taxonomy is missing. Attending NPO and/or attending taxonomy, when required is missing	206	National Provider Identifier - missing	N255	Missing-incomplete-invalid billing provider taxonomy.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

3091	Billing NPI and/or billing taxonomy is missing. Attending NPO and/or attending taxonomy, when required is missing	206	National Provider Identifier - missing	N251	Missing-incomplete-invalid attending provider taxonomy.	145	Entitys specialty code.
3091	Billing NPI and/or billing taxonomy is missing. Attending NPO and/or attending taxonomy, when required is missing	206	National Provider Identifier - missing	N255	Missing-incomplete-invalid billing provider taxonomy.	145	Entitys specialty code.
3091	Billing NPI and/or billing taxonomy is missing. Attending NPO and/or attending taxonomy, when required is missing	206	National Provider Identifier - missing	N251	Missing-incomplete-invalid attending provider taxonomy.	562	Entitys National Provider Identifier (NPI)
3091	Billing NPI and/or billing taxonomy is missing. Attending NPO and/or attending taxonomy, when required is missing	206	National Provider Identifier - missing	N255	Missing-incomplete-invalid billing provider taxonomy.	562	Entitys National Provider Identifier (NPI)
3092	Billing NPI and/or billing taxonomy is missing.	206	National Provider Identifier - missing	N255	Missing-incomplete-invalid billing provider taxonomy.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3092	Billing NPI and/or billing taxonomy is missing.	206	National Provider Identifier - missing	N255	Missing-incomplete-invalid billing provider taxonomy.	145	Entitys specialty code.
3092	Billing NPI and/or billing taxonomy is missing.	206	National Provider Identifier - missing	N255	Missing-incomplete-invalid billing provider taxonomy.	562	Entitys National Provider Identifier (NPI)
3093	Attending NPI and/or attending taxonomy, when required is missing.	206	National Provider Identifier - missing	N251	Missing-incomplete-invalid attending provider taxonomy.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3093	Attending NPI and/or attending taxonomy, when required is missing.	206	National Provider Identifier - missing	N251	Missing-incomplete-invalid attending provider taxonomy.	145	Entitys specialty code.
3093	Attending NPI and/or attending taxonomy, when required is missing.	206	National Provider Identifier - missing	N251	Missing-incomplete-invalid attending provider taxonomy.	562	Entitys National Provider Identifier (NPI)

3094	Referring NPI is missing.	206	National Provider Identifier - missing	N286	Missing-incomplete-invalid referring provider primary identifier.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3094	Referring NPI is missing.	206	National Provider Identifier - missing	N286	Missing-incomplete-invalid referring provider primary identifier.	562	Entitys National Provider Identifier (NPI)
3101	The taxonomy code for the attending provider is missing	A1	Claim-Service denied	N251	Missing-incomplete-invalid attending provider taxonomy.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3101	The taxonomy code for the attending provider is missing	A1	Claim-Service denied	N251	Missing-incomplete-invalid attending provider taxonomy.	145	Entitys specialty code
3102	The taxonomy code for the billing provider is missing	A1	Claim-Service denied	N255	Missing-incomplete-invalid billing provider taxonomy	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3102	The taxonomy code for the billing provider is missing	A1	Claim-Service denied	N255	Missing-incomplete-invalid billing provider taxonomy	145	Entitys specialty code
3103	The National Provider Identifier submitted is not found on the provider file	A1	Claim-Service denied	N280	Missing-incomplete-invalid pay-to provider primary identifier	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3103	The National Provider Identifier submitted is not found on the provider file	A1	Claim-Service denied	N280	Missing-incomplete-invalid pay-to provider primary identifier	562	Entitys National Provider Identifier (NPI)
3104	The National Provider Identifier submitted cannot be mapped to one provider number	A1	Claim-Service denied	N280	Missing-incomplete-invalid pay-to provider primary identifier	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

3104	The National Provider Identifier submitted cannot be mapped to one provider number	A1	Claim-Service denied	N280	Missing-incomplete-invalid pay-to provider primary identifier	562	Entitys National Provider Identifier (NPI)
3107	Claim should contain NPI only without the Medicaid Provider Number as provider is not atypical	A1	Claim-Service denied	N280	Missing-incomplete-invalid pay-to provider primary identifier	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3107	Claim should contain NPI only without the Medicaid Provider Number as provider is not atypical	A1	Claim-Service denied	N280	Missing-incomplete-invalid pay-to provider primary identifier	562	Entitys National Provider Identifier (NPI)
3208	Void or adjustment cannot be processed. Billing NPI does not match NPI on file for original provider	A1	Claim-Service denied	N257	Missing-incomplete-invalid billing provider-supplier primary identifier	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3208	Void or adjustment cannot be processed. Billing NPI does not match NPI on file for original provider	A1	Claim-Service denied	N257	Missing-incomplete-invalid billing provider-supplier primary identifier	562	Entitys National Provider Identifier (NPI)
3209	Void or adjustment cannot be processed. Billing NPI does not match NPI filed on original claim	A1	Claim-Service denied	M56	Missing-incomplete-invalid payer identifier	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3209	Void or adjustment cannot be processed. Billing NPI does not match NPI filed on original claim	A1	Claim-Service denied	M56	Missing-incomplete-invalid payer identifier	562	Entitys National Provider Identifier (NPI)
3210	RC634 must be billed with appropriate HCPC code.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

3410	Provider type and specialty 074-113 cannot bill Enhanced Benefit Services on or after date of service March 20, 2006	172	Payment is adjusted when performed-billed by a provider of this specialty	N95	This provider type - provider specialty may not bill this service.	187	Date(s) of service.
3410	Provider type and specialty 074-113 cannot bill Enhanced Benefit Services on or after date of service March 20, 2006	172	Payment is adjusted when performed-billed by a provider of this specialty	N351	Service date outside of the approved treatment plan service dates	187	Date(s) of service.
3410	Provider type and specialty 074-113 cannot bill Enhanced Benefit Services on or after date of service March 20, 2006	172	Payment is adjusted when performed-billed by a provider of this specialty	N95	This provider type - provider specialty may not bill this service.	454	Procedure code for services rendered
3410	Provider type and specialty 074-113 cannot bill Enhanced Benefit Services on or after date of service March 20, 2006	172	Payment is adjusted when performed-billed by a provider of this specialty	N351	Service date outside of the approved treatment plan service dates	454	Procedure code for services rendered
3411	Provider type and specialty 074-113 cannot bill Enhanced Benefit Services on or after date of service June 1, 2006	172	Payment is adjusted when performed-billed by a provider of this specialty	N95	This provider type - provider specialty may not bill this service.	187	Date(s) of service.
3411	Provider type and specialty 074-113 cannot bill Enhanced Benefit Services on or after date of service June 1, 2006	172	Payment is adjusted when performed-billed by a provider of this specialty	N351	Service date outside of the approved treatment plan service dates	187	Date(s) of service.
3411	Provider type and specialty 074-113 cannot bill Enhanced Benefit Services on or after date of service June 1, 2006	172	Payment is adjusted when performed-billed by a provider of this specialty	N95	This provider type - provider specialty may not bill this service.	454	Procedure code for services rendered
3411	Provider type and specialty 074-113 cannot bill Enhanced Benefit Services on or after date of service June 1, 2006	172	Payment is adjusted when performed-billed by a provider of this specialty	N351	Service date outside of the approved treatment plan service dates	454	Procedure code for services rendered

3412	Provider type and specialty 074-113 cannot bill Enhanced Benefit Services on or after date of service July 1, 2006	172	Payment is adjusted when performed-billed by a provider of this specialty	N95	This provider type - provider specialty may not bill this service.	187	Date(s) of service.
3412	Provider type and specialty 074-113 cannot bill Enhanced Benefit Services on or after date of service July 1, 2006	172	Payment is adjusted when performed-billed by a provider of this specialty	N351	Service date outside of the approved treatment plan service dates	187	Date(s) of service.
3412	Provider type and specialty 074-113 cannot bill Enhanced Benefit Services on or after date of service July 1, 2006	172	Payment is adjusted when performed-billed by a provider of this specialty	N95	This provider type - provider specialty may not bill this service.	454	Procedure code for services rendered
3412	Provider type and specialty 074-113 cannot bill Enhanced Benefit Services on or after date of service July 1, 2006	172	Payment is adjusted when performed-billed by a provider of this specialty	N351	Service date outside of the approved treatment plan service dates	454	Procedure code for services rendered
3413	Provider type and specialty 074-113 cannot bill Enhanced Benefit Services on and after date of service October 1, 2006	172	Payment is adjusted when performed-billed by a provider of this specialty	N95	This provider type - provider specialty may not bill this service.	187	Date(s) of service.
3413	Provider type and specialty 074-113 cannot bill Enhanced Benefit Services on and after date of service October 1, 2006	172	Payment is adjusted when performed-billed by a provider of this specialty	N351	Service date outside of the approved treatment plan service dates	187	Date(s) of service.
3413	Provider type and specialty 074-113 cannot bill Enhanced Benefit Services on and after date of service October 1, 2006	172	Payment is adjusted when performed-billed by a provider of this specialty	N95	This provider type - provider specialty may not bill this service.	454	Procedure code for services rendered
3413	Provider type and specialty 074-113 cannot bill Enhanced Benefit Services on and after date of service October 1, 2006	172	Payment is adjusted when performed-billed by a provider of this specialty	N351	Service date outside of the approved treatment plan service dates	454	Procedure code for services rendered

3414	Incorrect number of units billed for this service. Please correct and resubmit with corrected units	A1	Claim-Service denied	N142	The original claim was denied. Resubmit a new claim, not a replacement claim	476	Missing or invalid units of service
3800	A total of six stainless steel crowns allowed on same date of service. Allowance has been met	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	259	Frequency of service.
3800	A total of six stainless steel crowns allowed on same date of service. Allowance has been met	119	Benefit maximum for this time period or occurrence has been reached.	N59	Alert- Please refer to your provider manual for additional program and provider information	259	Frequency of service.
3800	A total of six stainless steel crowns allowed on same date of service. Allowance has been met	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.
3800	A total of six stainless steel crowns allowed on same date of service. Allowance has been met	119	Benefit maximum for this time period or occurrence has been reached.	N59	Alert- Please refer to your provider manual for additional program and provider information	483	Maximum coverage amount met or exceeded for benefit period.
3801	A total of six pulpotomies allowed on same date of service. Allowance has been met	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	259	Frequency of service.
3801	A total of six pulpotomies allowed on same date of service. Allowance has been met	119	Benefit maximum for this time period or occurrence has been reached.	N59	Alert- Please refer to your provider manual for additional program and provider information	259	Frequency of service.
3801	A total of six pulpotomies allowed on same date of service. Allowance has been met	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.
3801	A total of six pulpotomies allowed on same date of service. Allowance has been met	119	Benefit maximum for this time period or occurrence has been reached.	N59	Alert- Please refer to your provider manual for additional program and provider information	483	Maximum coverage amount met or exceeded for benefit period.
4014	Participant goods and services cutback to the maximum dollar amount allowed per State Fiscal Year (SFY)	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	483	Maximum coverage amount met or exceeded for benefit period.

4102	You are attempting to adjust a claim that is either not found on our file or is not found on our file as previously paid.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	1	For more detailed information, see remittance advice.
4102	You are attempting to adjust a claim that is either not found on our file or is not found on our file as previously paid.	125	Submission-billing error(s)	N152	Missing-incomplete-invalid replacement claim information.	1	For more detailed information, see remittance advice.
4102	You are attempting to adjust a claim that is either not found on our file or is not found on our file as previously paid.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	495	Requests for re-adjudication must reference the newly assigned payer claim control number for this previously adjusted claim. Correct the payer claim control number and resubmit.
4102	You are attempting to adjust a claim that is either not found on our file or is not found on our file as previously paid.	125	Submission-billing error(s)	N152	Missing-incomplete-invalid replacement claim information.	495	Requests for re-adjudication must reference the newly assigned payer claim control number for this previously adjusted claim. Correct the payer claim control number and resubmit.
4103	You are attempting to void a claim that is either not found on our file or is not found on our file as previously paid.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	1	For more detailed information, see remittance advice.

4103	You are attempting to void a claim that is either not found on our file or is not found on our file as previously paid.	125	Submission-billing error(s)	N152	Missing-incomplete-invalid replacement claim information.	1	For more detailed information, see remittance advice
4103	You are attempting to void a claim that is either not found on our file or is not found on our file as previously paid.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	495	Requests for re-adjudication must reference the newly assigned payer claim control number for this previously adjusted claim. Correct the payer claim control number and resubmit.
4103	You are attempting to void a claim that is either not found on our file or is not found on our file as previously paid.	125	Submission-billing error(s)	N152	Missing-incomplete-invalid replacement claim information.	495	Requests for re-adjudication must reference the newly assigned payer claim control number for this previously adjusted claim. Correct the payer claim control number and resubmit.
4406	Less severe dup, same prov, same pro code, same DOS.	18	Exact duplicate claim-service	M86	Service denied because payment already made for same-similar procedure within set time frame.	54	Duplicate of a previously processed claim-line.
4476	Units invalid for AD modifier	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M53	Missing-incomplete-invalid days or units of service.	453	Procedure Code Modifier(s) for Service(s) Rendered .
4476	Units invalid for AD modifier	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M53	Missing-incomplete-invalid days or units of service.	476	Missing or invalid units of service
5110	Provider enrollment indicator signifies provider must be enrolled in appropriate population group.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

5111	Provider number on claim does not match provider number on prior authorization record.	125	Submission-billing error(s)	N54	Claim information is inconsistent with pre-certified-authorized services.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
5112	Procedure code billed does not match procedure code on prior authorization record.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
5112	Procedure code billed does not match procedure code on prior authorization record.	125	Submission-billing error(s)	N188	The approved level of care does not match the procedure code submitted	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
5113	Type of service on claim does not match type of service on prior authorization record.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
5114	Tooth number billed does not match tooth number approved on prior authorization record.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

5117	Diagnosis billed on claim does not match diagnosis on prior authorization record.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
5118	Claim date(s) of service are outside authorized dates on prior authorization record. Resubmit prior approved dates of service only.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
5119	Payer determination cannot be made. Correct and resubmit claim.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
5200	Paid per modifier processing,.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA125	Per legislation governing this program, payment constitutes payment in full.	104	Processed according to plan provisions.
5203	Service rep by this procedure code-mod combination is not covered.	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct-valid for the service billed or the date of service billed.	453	Procedure Code Modifier(s) for Service(s) Rendered.
5203	Service rep by this procedure code-mod combination is not covered.	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct-valid for the service billed or the date of service billed.	457	Non-Covered Day(s).
5312	Prior authorized dollars exceeded.	198	Precertification-authorization exceeded	N54	Claim information is inconsistent with pre-certified-authorized services.	48	Referral-authorization.

5313	Prior authorized frequency exceeded.	198	Precertification-authorization exceeded	N54	Claim information is inconsistent with pre-certified-authorized services.	48	Referral-authorization.
5334	UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-2 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days-units for procedure-revenue code.
5334	UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-2 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	258	Days-units for procedure-revenue code.
5334	UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-2 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.
5334	UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-2 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	259	Frequency of service.
5606	FULL RECOUP FOLLOWING ITEM SYSTEM CHANGES, CLAIM WILL BE RESUBMITTED FOR YOU	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.
5606	FULL RECOUP FOLLOWING ITEM SYSTEM CHANGES, CLAIM WILL BE RESUBMITTED FOR YOU	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N185	Alert- Do not resubmit this claim-service	101	Claim was processed as adjustment to previous claim.
5607	FULL RECOUP, CLAIM PAID THROUGH ITME SYSTEM CHANGES WITHOUT PROPER PRIOR APPROVAL	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	65	Claim-line has been paid.
5607	FULL RECOUP, CLAIM PAID THROUGH ITME SYSTEM CHANGES WITHOUT PROPER PRIOR APPROVAL	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.
6001	Encounter: Admission date-date of service missing or invalid. Verify date of service and resubmit.		No Mapping Required		No Mapping Required		No Mapping Required

6016	Resubmit with invoice.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and/or invalid information and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
6027	Diagnosis code missing or invalid. Verify all diagnosis codes and resubmit.	146	Diagnosis was invalid for the date(s) of service reported.	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
6071	Test for antepartum sex determination is non-covered.	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M79	Missing-incomplete-invalid charge.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
6071	Test for antepartum sex determination is non-covered.	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N115	This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD).	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
6071	Test for antepartum sex determination is non-covered.	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M79	Missing-incomplete-invalid charge.	454	Procedure code for services rendered.
6071	Test for antepartum sex determination is non-covered.	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N115	This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD).	454	Procedure code for services rendered.

6082	Encounter: Negative amount was submitted on your claim. Negative values are not permitted. Please correct and resubmit		No Mapping Required		No Mapping Required		No Mapping Required
6083	Only 4 quadrants of periodontal scaling and root planing allowed every 2 years	119	Benefit maximum for this time period or occurrence has been reached.	N357	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	259	Frequency of service.
6099	Encounter: Billed services have been approved.		No Mapping Required		No Mapping Required		No Mapping Required
6136	UB revenue code invalid this bill type; CMS 1500 claims place of service missing-invalid for this procedure. Correct bill type or POS and resubmit.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
6149	Diagnosis or service invalid for recipient age. Verify MID, diagnosis & procedure code; enter and resubmit.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
6192	Encounter: Diag. Or SVC. invalid for recip. age. Verify mid, diag., & proc. code and resubmit.		No Mapping Required		No Mapping Required		No Mapping Required
6224	Encounter: unlisted procedures are non-covered. Correct claim & resubmit.		No Mapping Required		No Mapping Required		No Mapping Required

6260	Recipient mid number missing. Enter mid and resubmit.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
6261	Patient deceased per state eligibility file. Verify DOS and recipient mid and resubmit.	30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.		No Mapping Required	91	Entity not eligible-not approved for dates of service.
6267	DOS is prior to date of birth. Verify DOS and recipient mid and resubmit.	14	The date of birth follows the date of service.	MA61	Missing-incomplete-invalid social security number or health insurance claim number.	91	Entity not eligible-not approved for dates of service.
6300	Plan number missing or invalid. Enter corrected managed care plan number on the claim and resubmit.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
6300	Plan number missing or invalid. Enter corrected managed care plan number on the claim and resubmit.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	515	Managed Care review
6337	Procedure code missing or invalid.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

6338	Encounter: this code has not been approved to be billed by dentists.		No Mapping Required		No Mapping Required		No Mapping Required
6647	This service is covered by the MCO for recipient's county and this recipient's claims must be submitted directly to the MCO/LME for payment	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity. Note: This code requires use of an Entity Code
6701	Services covered by united healthcare. Please contact the HMO plan's member services at 1-877-289-4419.	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.
6701	Services covered by united healthcare. Please contact the HMO plan's member services at 1-877-289-4419.	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	585	Denied Charge or Non-covered Charge.
6702	Service covered by Piedmont Cardinal Health Plan Ph:800-958-5596	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.
6702	Service covered by Piedmont Cardinal Health Plan Ph:800-958-	24	Charges are covered under a		No Mapping Required	585	Denied Charge or Non-

6704	Service covered by ATLANTIC HEALTH PLANS - please contact HMO's member service # 1-800-643-8483	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	585	Denied Charge or Non-covered Charge.
6705	Service covered by MAXICARE N.C. Please contact member service # 1-800-350-6294	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.
6705	Service covered by MAXICARE N.C. Please contact member service # 1-800-350-6294	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	585	Denied Charge or Non-covered Charge.
6707	Service covered by WELLNESS PLAN OF N.C. Please contact member service # 1-800-794-9355	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.
6707	Service covered by WELLNESS PLAN OF N.C. Please contact member service # 1-800-794-9355	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	585	Denied Charge or Non-covered Charge.
6708	Service covered by OPTIMUM CHOICE. Please contact member service # 1-800-794-9355	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.
6708	Service covered by OPTIMUM CHOICE. Please contact member service # 1-800-794-9355	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	585	Denied Charge or Non-covered Charge.
6711	Services covered by SOUTHCARE-COVENTY. Please contact the HMO PLAN's member services at 1-800-350-6294	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.
6711	Services covered by SOUTHCARE-COVENTY. Please contact the HMO PLAN's member services at 1-800-350-6294	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	585	Denied Charge or Non-covered Charge.
6900	Encounter data withhold has been applied		No Mapping Required		No Mapping Required		No Mapping Required
6901	Encounter data withhold has been released		No Mapping Required		No Mapping Required		No Mapping Required

6909	Retroactive monthly capitated payment is prorated to match recipient eligibility for the month		No Mapping Required		No Mapping Required	107	Processed according to contract-plan provisions.
6960	Encounter: fees have been previously recouped. Upon subsequent review, reimbursement is being returned through this transaction.		No Mapping Required		No Mapping Required		No Mapping Required
6961	Due to a system error, claim paid incorrectly and has been recouped. Service for this recipient are covered by Kaiser. Please contact the HMO's member service # at 1-800-800-0901	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.
6961	Due to a system error, claim paid incorrectly and has been recouped. Service for this recipient are covered by Kaiser. Please contact the HMO's member service # at 1-800-800-0901	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	684	Rejected. Syntax error noted for this claim-service-inquiry. See Functional or Implementation Acknowledgement for details.
6962	Please contact ATLANTIC member service at 1-800-643-8483	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.
6962	Please contact ATLANTIC member service at 1-800-643-8483	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	684	Rejected. Syntax error noted for this claim-service-inquiry. See Functional or Implementation Acknowledgement for details.
6963	PLEASE CONTACT MAXICARE AT 1-800-350-6294	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.

6963	PLEASE CONTACT MAXICARE AT 1-800-350-6294	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	684	Rejected. Syntax error noted for this claim-service-inquiry. See Functional or Implementation Acknowledgement for details.
6964	PLEASE CONTACT GENERATIONS AT 1-800-256-5563	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.
6964	PLEASE CONTACT GENERATIONS AT 1-800-256-5563	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	684	Rejected. Syntax error noted for this claim-service-inquiry. See Functional or Implementation Acknowledgement for details.
6965	PLEASE CONTACT WELLNESS AT 1-800-794-9355	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.
6965	PLEASE CONTACT WELLNESS AT 1-800-794-9355	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	684	Rejected. Syntax error noted for this claim-service-inquiry. See Functional or Implementation Acknowledgement for details.
6966	Please contact Optimum at 1-800-347-1957.	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.
6966	Please contact Optimum at 1-800-347-1957.	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	684	Rejected. Syntax error noted for this claim-service-inquiry. See Functional or Implementation Acknowledgement for details.
6967	Please contact United Health Care at 1-877-289-4419.	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.
6967	Please contact United Health Care at 1-877-289-4419.	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	684	Rejected. Syntax error noted for this claim-service-inquiry. See Functional or Implementation Acknowledgement for details.

6996	Encounter: patient not covered under plan during date(s) of service.		No Mapping Required		No Mapping Required		No Mapping Required
6997	Encounter: service(s) submitted not covered under plan schedule of Medicaid benefits.		No Mapping Required		No Mapping Required		No Mapping Required
7022	NO FURTHER PAYMENT FOR THIS SERVICE	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	107	Processed according to contract-plan provisions.
7022	NO FURTHER PAYMENT FOR THIS SERVICE	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	483	Maximum coverage amount met or exceeded for benefit period.
7718	Coronary intervention service is not consistent with-or not covered for this diagnosis.	11	The diagnosis is inconsistent with the procedure.	MA66	Missing-incomplete-invalid principal procedure code or date.	488	Diagnosis code(s) for the services rendered
7722	Medicaid does not allow assistant at surgery on the same date of service as the procedure performed by two surgeons or a surgical team.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
7724	Diagnosis does not support billing of debridement of nails per MCD guidelines.	11	The diagnosis is inconsistent with the procedure.	M76	Missing-incomplete-invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered
7729	Diagnosis billed does not met MCD guidelines for paring and cutting of lesions or trimming of nondystrophic nails.	11	The diagnosis is inconsistent with the procedure.	M76	Missing-incomplete-invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered
7753	Monitored anesthesia not supported by diagnosis.	11	The diagnosis is inconsistent with the procedure.	M76	Missing-incomplete-invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered

7754	Exceeds 2 proc-2 days limit.	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	259	Frequency of service.
7754	Exceeds 2 proc-2 days limit.	119	Benefit maximum for this time period or occurrence has been reached.	N357	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	259	Frequency of service.
8039	Exceeds maximum allowed for a permanent posterior composite on a single tooth	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	178	Submitted charges.
8050	Payment has been reduced to the same total reimbursement as the four surface resin-based composite restoration for a	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO	N2	This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.	66	Payment reflects usual and customary charges.
8050	Payment has been reduced to the same total reimbursement as the four surface resin-based composite restoration for a	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	66	Payment reflects usual and customary charges.
8053	DOS include 10/01/2011. Split claims by DOS and bill DOS prior to 10/01/2011 separately to DMA. DOS on/after 10/01/2011 should be billed separately to HPES	A1	Claim-Service denied. At least one Remark Code must be provided may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.	M52	Missing-incomplete-invalid from date(s) of service.	197	Effective coverage dates.
8060	Payment has been reduced to the same total reimbursement as the four or more surfaces amalgam restoration	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N2	This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.	66	Payment reflects usual and customary charges.
8060	Payment has been reduced to the same total reimbursement as the four or more surfaces amalgam restoration	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	66	Payment reflects usual and customary charges.
8069	Exceeds maximum allowed for a posterior amalgam on a single tooth	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	178	Submitted charges.

8109	Dollar limitation amount for training and education services cutback to the allowable maximum per waiver year	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.
8110	Dollar limitation amount for assistive technology cutback to the allowable maximum per lifetime of the waiver	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.
8326	ATTENDING PROVIDER ID IS MISSING OR UNRESOLVED. ATTENDING PROV IS REQUIRED. VERIFY ATTENDING PROVIDER ID AND RESUBMIT AS A NEW CLAIM OR CONTACT HP PROV SVCS IF ID IS CORRECT	A1	Claim-Service denied	N253	Missing-incomplete-invalid attending provider primary identifier	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
8326	ATTENDING PROVIDER ID IS MISSING OR UNRESOLVED. ATTENDING PROV IS REQUIRED. VERIFY ATTENDING PROVIDER ID AND RESUBMIT AS A NEW CLAIM OR CONTACT HP PROV SVCS IF ID IS CORRECT	A1	Claim-Service denied	N253	Missing-incomplete-invalid attending provider primary identifier	562	Entitys National Provider Identifier (NPI)
8327	Attending provider ID cannot be billed in combination with group ID listed. Verify attending provider ID and resubmit as new claim or contact HP Prov Svc if ID is correct	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

8327	ATTENDING PROVIDER ID CANNOT BE BILLED IN COMBINATION WITH GROUP ID LISTED. VERIFY ATTENDING PROVIDER ID AND RESUBMIT AS NEW CLAIM OR CONTACT HP PROV SVC IF ID IS CORRECT	125	Submission-billing error(s)	N272	Missing-incomplete-invalid other payer attending provider identifier.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
8328	ATTENDING PROVIDER NOT ELIGIBLE ON SERVICE DATE.	52	The referring-prescribing-rendering provider is not eligible to refer-prescribe-order-perform the service billed.		No Mapping Required	91	Entity not eligible-not approved for dates of service.
8407	Please file Medicare covered service to part b carrier for processing. If Medicare has denied this service, resubmit to HP as an adjustment request with Medicare voucher.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	MA92	Missing-incomplete-invalid plan information for other insurance.	286	Other payers explanation of benefits-payment information.
8407	Please file Medicare covered service to part b carrier for processing. If Medicare has denied this service, resubmit to HP as an adjustment request with Medicare voucher.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N1	Alert- You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	286	Other payers explanation of benefits-payment information.
8700	Per Legislative Mandate this medicaid claim must be filed electronically for adjudication.	A1	Claim-Service denied	M117	Not covered unless submitted via electronic claim.	275	Claim.
8700	Per Legislative Mandate this medicaid claim must be filed electronically for adjudication.	A1	Claim-Service denied	M117	Not covered unless submitted via electronic claim.	481	Claim-submission format is invalid.
8701	Refile as an adjustment and attach medical records, operative notes, federal statements or other pertinent documenation.	16	Claim-service lacks information which is needed for adjudication	M117	Not covered unless submitted via electronic claim.	294	Supporting documentation.

8701	Refile as an adjustment and attach medical records, operative notes, federal statements or other pertinent documentation.	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes-summary-report-chart.	294	Supporting documentation.
8701	Refile as an adjustment and attach medical records, operative notes, federal statements or other pertinent documentation.	16	Claim-service lacks information which is needed for adjudication	M117	Not covered unless submitted via electronic claim.	317	Patients medical records.
8701	Refile as an adjustment and attach medical records, operative notes, federal statements or other pertinent documentation.	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes-summary-report-chart.	317	Patients medical records.
8702	PLEASE REFER TO CLINICAL POLICY NUMBER 1A-22 FOR COVERAGE CRITERIA FOR MEDICALLY NECESSARY CIRCUMCISIONS. RESUBMIT WITH MEDICAL RECORD DOCUMENTATION SUPPORTING CLAIM	202	Non-covered personal comfort or convenience services.	M16	Alert- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	294	Supporting documentation.
8702	PLEASE REFER TO CLINICAL POLICY NUMBER 1A-22 FOR COVERAGE CRITERIA FOR MEDICALLY NECESSARY CIRCUMCISIONS. RESUBMIT WITH MEDICAL RECORD DOCUMENTATION SUPPORTING CLAIM	202	Non-covered personal comfort or convenience services.	M16	Alert- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	317	Patients medical records.
8826	Payment reduced for Medicare TPL payment, paid up to the Estimated Amount Due	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N9	Adjustment represents the estimated amount a previous payer may pay.	107	Processed according to contract-plan provisions.

8826	Payment reduced for Medicare TPL payment, paid up to the Estimated Amount Due	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	107	Processed according to contract-plan provisions.
8826	Payment reduced for Medicare TPL payment, paid up to the Estimated Amount Due	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.
8826	Payment reduced for Medicare TPL payment, paid up to the Estimated Amount Due	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N9	Adjustment represents the estimated amount a previous payer may pay.	182	Allowable-paid from primary coverage
8826	Payment reduced for Medicare TPL payment, paid up to the Estimated Amount Due	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	182	Allowable-paid from primary coverage
8826	Payment reduced for Medicare TPL payment, paid up to the Estimated Amount Due	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	182	Allowable-paid from primary coverage
8827	Claim submitted indicates Medicare payment. The sum of coinsurance and deductible amounts must be placed in the estimated amount due field locator 55.	148	Information from another provider was not provided or was insufficient-incomplete	MA07	Alert- The claim information has also been forwarded to Medicaid for review	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
8827	Claim submitted indicates Medicare payment. The sum of coinsurance and deductible amounts must be placed in the estimated amount due field locator 55.	148	Information from another provider was not provided or was insufficient-incomplete	MA07	Alert- The claim information has also been forwarded to Medicaid for review	123	Additional information requested from entity.
8827	Claim submitted indicates Medicare payment. The sum of coinsurance and deductible amounts must be placed in the estimated amount due field locator 55.	148	Information from another provider was not provided or was insufficient-incomplete	MA07	Alert- The claim information has also been forwarded to Medicaid for review	565	Estimated Claim Due Amount

8912	Charges have been combined to paid detail.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N45	Payment based on authorized amount.	12	One or more originally submitted procedure codes have been combined.
8912	Charges have been combined to paid detail.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N45	Payment based on authorized amount.	178	Submitted charges.
8913	The ICN referenced on adjustment request does not match the claim which requires adjusting. Please check and correct the reference ICN then resubmit the adjustment request.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
8918	Insufficient doc. To warrant time limit override. Submit resolution inquiry with claim & proof of timely filing-prev.ra,time override letter, other ins.voucher within last 6 mos.	16	Claim-service lacks information which is needed for adjudication	N1	Alert- You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	104	Processed according to plan provisions.
8918	Insufficient doc. To warrant time limit override. Submit resolution inquiry with claim & proof of timely filing-prev.ra,time override letter, other ins.voucher within last 6 mos.	16	Claim-service lacks information which is needed for adjudication	N225	Incomplete-invalid documentation-orders-notes-summary-report-chart.	104	Processed according to plan provisions.
8923	Claim paid for prior approved dates of service only.	198	Precertification-authorization exceeded	N54	Claim information is inconsistent with pre-certified-authorized services.	65	Claim-line has been paid.
8925	Allowable reduced for deductible-patient liability-other insurance payment-other insurance.	142	Monthly Medicaid patient liability amount.		No Mapping Required	85	Entity not primary.

8926	Allowable reduced for other insurance payment	23	The impact of prior payer(s) adjudication including payments and-or adjustments		No Mapping Required	182	Allowable-paid from primary coverage
8927	Allowable reduced for deductible-patient liability-other insurance payment-other insurance.	142	Monthly Medicaid patient liability amount.		No Mapping Required	85	Entity not primary.
8928	Medicaid DRG allowable is less than what Medicare Paid.	A8	Ungroupable DRG	N45	Payment based on authorized amount.	256	DRG code(s).
8929	DRG payment reflects Medicaid DRG amount less the Medicare payment.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N131	Total payments under multiple contracts cannot exceed the allowance for this service.	532	Claim DRG Amount
8929	DRG payment reflects Medicaid DRG amount less the Medicare payment.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	532	Claim DRG Amount
8929	DRG payment reflects Medicaid DRG amount less the Medicare payment.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	532	Claim DRG Amount
8930	DRG: Medicare Coinsurance-Deductible Paid.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	256	DRG code(s).
8930	DRG: Medicare Coinsurance-Deductible Paid.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	256	DRG code(s).
8988	Claim denied. Provider was not endorsed-licensed-certified on date of service	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service	N185	Alert- Do not resubmit this claim-service	142	Entitys license-certification number
9006	Claim suspended due to bad address on provider file.	133	The disposition of this claim-service is pending further review.	N258	Missing-incomplete-invalid billing provider-supplier address.	3	Claim has been adjudicated and is awaiting payment cycle.
9098	Recipient is enrolled in Healthchoice on from date of service. Please file your claim with Blue Cross Blue Shield	109	Claim not covered by this payer-contractor. You must send the claim to the correct payer-contractor	M56	Missing-incomplete-invalid payer identifier.	91	Entity not eligible-not approved for dates of service.

9098	Recipient is enrolled in Healthchoice on from date of service. Please file your claim with Blue Cross Blue Shield	109	Claim not covered by this payer-contractor. You must send the claim to the correct payer-contractor	N193	Specific federal-state-local program may cover this service through another payer	91	Entity not eligible-not approved for dates of service.
9098	Recipient is enrolled in Healthchoice on from date of service. Please file your claim with Blue Cross Blue Shield	109	Claim not covered by this payer-contractor. You must send the claim to the correct payer-contractor	M56	Missing-incomplete-invalid payer identifier.	116	Claim submitted to incorrect payer.
9098	Recipient is enrolled in Healthchoice on from date of service. Please file your claim with Blue Cross Blue Shield	109	Claim not covered by this payer-contractor. You must send the claim to the correct payer-contractor	N193	Specific federal-state-local program may cover this service through another payer	116	Claim submitted to incorrect payer.
9098	Recipient is enrolled in Healthchoice on from date of service. Please file your claim with Blue Cross Blue Shield	109	Claim not covered by this payer-contractor. You must send the claim to the correct payer-contractor	M56	Missing-incomplete-invalid payer identifier.	187	Date(s) of service
9098	Recipient is enrolled in Healthchoice on from date of service. Please file your claim with Blue Cross Blue Shield	109	Claim not covered by this payer-contractor. You must send the claim to the correct payer-contractor	N193	Specific federal-state-local program may cover this service through another payer	187	Date(s) of service
9180	An ICD-9cm code supporting the medical nec.of this service must be submitted on claim. Refile with appropriate diagnosis code.	11	The diagnosis is inconsistent with the procedure.	M76	Missing-incomplete-invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered.
9290	DRG - discharge claim already received.	B13	Previously paid. Payment for this claim-service may have been provided in a previous payment.		No Mapping Required	256	DRG code(s).
9291	Provider must rebill after dates of service have met the 60 day interval.	A1	Claim-Service denied	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

9294	DRG recoupment.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.
9294	DRG recoupment.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	256	DRG code(s).
9295	DRG recoupment: No activity on paid interim for 180 days. Please bill next interim or final (discharge) claim. If discharge claim has been submitted, disregard this message.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.
9295	DRG recoupment: No activity on paid interim for 180 days. Please bill next interim or final (discharge) claim. If discharge claim has been submitted, disregard this message.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	256	DRG code(s).
9600	Adjustment Denied. The EOB this claim previously denied with does not require adjusting. Correct/Resubmit claim in lieu of adjustment request.	133	The disposition of this claim-service is pending further review.		No Mapping Required	3	Claim has been adjudicated and is awaiting payment cycle.
9601	Adjustment denied: claim denied correctly. This provider has previously billed and been paid for services rendered on this date of service.	18	Exact duplicate claim-service	M86	Service denied because payment already made for same-similar procedure within set time frame.	54	Duplicate of a previously processed claim-line.
9602	Adjustment denied: Claim denied correctly. Only one E-M service allowed per day per provider specialty without documentation of medical justification.	151	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services		No Mapping Required	259	Frequency of service.

9602	Adjustment denied: Claim denied correctly. Only one E-M service allowed per day per provider specialty without documentation of medical justification.	151	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services		No Mapping Required	612	Per Day Limit Amount
9604	Adj denied, service is considered part of surgical F-U.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA91	This determination is the result of the appeal you filed.	454	Procedure code for services rendered.
9605	Adj denied, medical necessity not apparent for two providers of the same specialty to render service for this unrelated diagnosis.	18	Exact duplicate claim-service		No Mapping Required	414	Need for more than one physician to treat patient.
9606	Adjustment denied, service rendered by same provider specialty as previously paid surgery.	18	Exact duplicate claim-service	M86	Service denied because payment already made for same-similar procedure within set time frame.	54	Duplicate of a previously processed claim-line.
9607	Adjustment being reviewed for change in patient liability, do not refile your adjustment, it will be processed upon completion of review.	142	Monthly Medicaid patient liability amount.	N58	Missing-incomplete-invalid patient liability amount.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9607	Adjustment being reviewed for change in patient liability, do not refile your adjustment, it will be processed upon completion of review.	142	Monthly Medicaid patient liability amount.	N185	Alert- Do not resubmit this claim-service	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

9608	Discharge code to be used by the attending physician only.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9609	ER service pd in history for the same time of service and same day in which medical screening exam fee billed.	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same-similar procedure within set time frame.	258	Days-units for procedure-revenue code.
9610	Medical screening exam fee recouped. ER service have been paid.	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same-similar procedure within set time frame.	259	Frequency of service.
9611	Medical Screening exam fee recouped. Service was authorized-true emergency. Refile claim for ER service.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.
9613	Adjustment denied: Claim processed correctly according to the Medicaid guidelines in effect at the time of the original processing.	193	Original payment decision is being maintained. This claim was processed properly the first time	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	101	Claim was processed as adjustment to previous claim.

9613	Adjustment denied: Claim processed correctly according to the Medicaid guidelines in effect at the time of the original processing.	193	Original payment decision is being maintained. This claim was processed properly the first time	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.
9614	Claim denied. Provider number and-or type of bill invalid, resubmit with correct provider number and-or type of bill for services rendered.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9615	Adj. Denied: Request is being forwarded to Provider Services. In the future, submit request of this type on a resolution inquiry form.	A1	Claim-Service denied	N34	Incorrect claim form-format for this service.	481	Claim-submission format is invalid.
9616	Adjustment request is being held pending review of medical records from all parties.	133	The disposition of this claim-service is pending further review.	N185	Alert- Do not resubmit this claim-service	317	Patients medical records.
	Per diem; Medicare coinsurance-						

9626	Per diem; Medicare coinsurance-deductible paid.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	65	Claim-line has been paid.
9626	Per diem; Medicare coinsurance-deductible paid.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	107	Processed according to contract-plan provisions
9626	Per diem; Medicare coinsurance-deductible paid.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions
9627	Per diem: payment reflects Medicaid per diem amount less the Medicare payment.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	65	Claim-line has been paid.
9627	Per diem: payment reflects Medicaid per diem amount less the Medicare payment.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	65	Claim-line has been paid
9627	Per diem: payment reflects Medicaid per diem amount less the Medicare payment.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	107	Processed according to contract-plan provisions
9627	Per diem: payment reflects Medicaid per diem amount less the Medicare payment.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions
9628	Medicaid pays Medicaid per diem allowable less Medicare payment, therefore payment is zero.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N45	Payment based on authorized amount.	104	Processed according to plan provisions.
9629	Per diem; paid all Medicaid eligible days less the Medicare payment.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	65	Claim-line has been paid.

9629	Per diem; paid all Medicaid eligible days less the Medicare payment.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	65	Claim-line has been paid.
9629	Per diem; paid all Medicaid eligible days less the Medicare payment.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	107	Processed according to contract-plan provisions
9629	Per diem; paid all Medicaid eligible days less the Medicare payment.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions
9630	Adjustment denied. When billing for additional dates of service, file a new claim for those dates instead of filing an adjustment.	A1	Claim-Service denied	N517	Resubmit a new claim with the requested information.	481	Claim-submission format is invalid.
9666	System processing error - Claim will be resubmitted for you. Watch future R-A for disposition.	101	Predetermination: anticipated payment upon completion of services or claim adjudication.	N185	Alert- Do not resubmit this claim-service	101	Claim was processed as adjustment to previous claim.
9795	DOS span includes 10/01/2011. Claim must be split by DOS and dates prior to 10/01/2011 billed seperately to BCBS. Dates on/after 10/01/2011 billed separately to HPES	A1	Claim-Service denied	M52	Missing-incomplete-invalid from date(s) of service.	197	Effective coverage date(s).
9796	Claim involves details/DOS indicating the recipient is enrolled in different programs. Claim must be split out to include "only" Medicaid or SCHIP services per claim	A1	Claim-Service denied	M52	Missing-incomplete-invalid from date(s) of service.	91	Entity not eligible-not approved for dates of service.
9797	This recipient not eligible for this NCHC (SCHIP) service for the date of service billed	A1	Claim-Service denied	N30	Patient ineligible for this service.	91	Entity not eligible-not approved for dates of service.

9798	Claim denied, recipient's eligibility indicates Health Choice for uninsured children. Claim indicates recipient/services were subject to other health care coverage	A1	Claim-Service denied	N196	Alert-Patient eligible to apply for other coverage which may be primary.	91	Entity not eligible-not approved for dates of service.
9811	FULL RECOUP-CLAIM DATES SPAN 10/01/11. CLAIM MUST BE SPLIT. SUBMIT DATES PRIOR TO 10/01/2011 SEPARATELY TO BCBS. SUBMIT DATES ON/AFTER 10/01/11 SEPARATELY TO HPES	A1	Claim-Service denied	M52	Missing-incomplete-invalid from date(s) of service.	197	Effective coverage date(s).
9904	CMS 1500 claim with more than 3 NDC's per procedure code must be billed electronically.	A1	Claim-Service denied	M117	Not covered unless submitted via electronic claim.	216	Drug information.
9904	CMS 1500 claim with more than 3 NDC's per procedure code must be billed electronically.	A1	Claim-Service denied	M117	Not covered unless submitted via electronic claim.	217	Drug name, strength and dosage form.
9904	CMS 1500 claim with more than 3 NDC's per procedure code must be billed electronically.	A1	Claim-Service denied	M117	Not covered unless submitted via electronic claim.	218	NDC number.
9960	RESUBMIT ON THE NEW UBO4 CLAIM FORM	A1	Claim-Service denied	N34	Incorrect claim form-format for this service.	276	UB04-HCFA-1450-1500 claim form .
9960	RESUBMIT ON THE NEW UBO4 CLAIM FORM	A1	Claim-Service denied	N34	Incorrect claim form-format for this service.	481	Claim-submission format is invalid.
9990	Adjustment reflects retroactive rate increase that was effective 7-01-96 for code w8010.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N45	Payment based on authorized amount.	64	Re-pricing information.

9991	CLAIM DENIED DUE TO SUBMISSION ON OLD CMS 1500 FORMAT AFTER 7/1/2007 DEADLINE. RESUBMIT ON NEW CMS 1500 FORMAT. REFER TO JUNE 2007 SPECIAL BULLENTIN	A1	Claim-Service denied	M16	Alert- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision. N34 - Incorrect claim form-format for this service.	276	UB04-HCFA-1450-1500 claim form.
9991	CLAIM DENIED DUE TO SUBMISSION ON OLD CMS 1500 FORMAT AFTER 7/1/2007 DEADLINE. RESUBMIT ON NEW CMS 1500 FORMAT. REFER TO JUNE 2007 SPECIAL BULLENTIN	A1	Claim-Service denied	N130	Alert- Consult plan benefit documents for information about restrictions for this service	276	UB04-HCFA-1450-1500 claim form.
9991	CLAIM DENIED DUE TO SUBMISSION ON OLD CMS 1500 FORMAT AFTER 7/1/2007 DEADLINE. RESUBMIT ON NEW CMS 1500 FORMAT. REFER TO JUNE 2007 SPECIAL BULLENTIN	A1	Claim-Service denied	M16	Alert- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision. N34 - Incorrect claim form-format for this service.	481	Claim-submission format is invalid
9991	CLAIM DENIED DUE TO SUBMISSION ON OLD CMS 1500 FORMAT AFTER 7/1/2007 DEADLINE. RESUBMIT ON NEW CMS 1500 FORMAT. REFER TO JUNE 2007 SPECIAL BULLENTIN	A1	Claim-Service denied	N130	Alert- Consult plan benefit documents for information about restrictions for this service	481	Claim-submission format is invalid

9993	DRUG DISPENSED IS INVALID FOR RECIPIENT AGA AND/OR SEX. PLEASE RESUBMIT PAPER CLAIM WITH DIAGNOSIS WRITTEN AT THE BOTTOM OF THE FORM	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9993	DRUG DISPENSED IS INVALID FOR RECIPIENT AGA AND/OR SEX. PLEASE RESUBMIT PAPER CLAIM WITH DIAGNOSIS WRITTEN AT THE BOTTOM OF THE FORM	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	255	Diagnosis code
9994	IV solutions 500 mls or greater per bag are non-covered for patients in ICF or SNF. We pay the nursing home per diem for these, so the nursing home should be billed, not Medicaid.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	65	Claim-line has been paid.
9996	Repaid per EDS audit. Payment reflects updated rates, per diems and-or payment method.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N45	Payment based on authorized amount.	64	Re-pricing information.
9997	Previous 'Interim Payment' for 8-95 & 9-95 dates of service is being adjusted to correct under-over payment. See paid claims section of Remittance Advise for corrected payment.	B5	Coverage-program guidelines were not met or were exceeded.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions
9998	System generated adjustment-recoupment for medical policy audits. Internal use only.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N45	Payment based on authorized amount.	104	Processed according to plan provisions.

9999	Audit-edit overflow-system.	45	Charge exceeds fee schedule- maximum allowable or contracted- legislated fee arrangement	N45	Payment based on authorized amount.	104	Processed according to plan provisions.
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