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
2	**Pre-admission not obtained**	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	435	Notice of Admission
3	**Consecutive dates of service cannot be billed. List each date separately and resubmit**	125	Submission-billing error(s)	N63	Rebill services on separate claims.	187	Date(s) of service.
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.
5	**NDC missing, invalid or not on state file. Correct 11 digit code required. Valid compound NDC - or compound indicator and all ingredient NDC's required, see Pharmacy manual**	125	Submission-billing error(s)	M119	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	21	Missing or invalid information.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.

5	**NDC missing, invalid or not on state file. Correct 11 digit code required. Valid compound NDC - or compound indicator and all ingredient NDC's required, see Pharmacy manual**	**125**	Submission-billing error(s)	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
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.
7	**Recipient not eligible for CAP**	**177**	Patient has not met the required eligibility requirements.	**N30**	Patient ineligible for this service.	**90**	Entity not eligible for medical benefits for submitted dates of service. Note- This code requires use of an Entity Code.
7	**Recipient not eligible for CAP**	**177**	Patient has not met the required eligibility requirements.	**N30**	Patient ineligible for this service.	**109**	Entity not eligible. Note- This code requires use of an Entity Code.
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.
9	**Service not covered under the recipient's benefit package; Pharmacy: see non-covered items under scope of services in manual**	**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	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9	**Service not covered under the recipient's benefit package; Pharmacy: see non-covered items under scope of services in manual**	**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	**454**	Procedure code for services rendered.

10	**Diagnosis or service invalid for recipient age, Verify MID, diagnosis, procedure code or procedure code- modifier combination for errors. Correct and submit as a new claim**	**125**	Submission-billing error(s)	**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.
10	**Diagnosis or service invalid for recipient age, Verify MID, diagnosis, procedure code or procedure code- modifier combination for errors. Correct and submit as a new claim**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
10	**Diagnosis or service invalid for recipient age, Verify MID, diagnosis, procedure code or procedure code- modifier combination for errors. Correct and submit as a new claim**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**475**	Procedure code not valid for patient age.
10	**Diagnosis or service invalid for recipient age, Verify MID, diagnosis, procedure code or procedure code- modifier combination for errors. Correct and submit as a new claim**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid diagnosis or condition.	**475**	Procedure code not valid for patient age.
10	**Diagnosis or service invalid for recipient age, Verify MID, diagnosis, procedure code or procedure code- modifier combination for errors. Correct and submit as a new claim**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.

10	**Diagnosis or service invalid for recipient age, Verify MID, diagnosis, procedure code or procedure code- modifier combination for errors. Correct and submit as a new claim**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.
11	**Recipient not eligible on service date**	**177**	Patient has not met the required eligibility requirements.	**N30**	Patient ineligible for this service.	**90**	Entity not eligible for medical benefits for submitted dates of service. Note- This code requires use of an Entity Code.
11	**Recipient not eligible on service date**	**177**	Patient has not met the required eligibility requirements.	**N30**	Patient ineligible for this service.	**109**	Entity not eligible. Note- This code requires use of an Entity Code.
12	**Diagnosis or service invalid for recipient sex**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**86**	Diagnosis and patient gender mismatch.
12	**Diagnosis or service invalid for recipient sex**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**474**	Procedure code and patient gender mismatch.
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.
16	**Payment included in HEALTH CHECK fee**	**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.
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.
18	**Claim denied. No history to justify time limit override. Claims with proper documentation should be sumbitted to the HP Provider Service Unit**	**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.
19	**Correct date of service to delivery - surgery date only and submit as a new claim**	**125**	Submission-billing error(s)	**MA67**	Correction to a prior claim.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
19	**Correct date of service to delivery - surgery date only and submit as a new claim**	**125**	Submission-billing error(s)	**MA67**	Correction to a prior claim.	**187**	Date(s) of service.

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.
23	**Service requires prior approval**	**197**	Precertification-authorization-notification absent.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**84**	Service not authorized.
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.
26	**Ventilator care not payable to this provider type**	**170**	Payment is denied when performed-billed by this type of provider. 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.	**25**	Entity not approved.
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.
34	**Please indicate Part B Medicare payment in Form Locator 54 and resubmit as a new claim**	**148**	Information from another provider was not provided or was insufficient-incomplete	**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.
35	**Claim/procedure denied, services not rendered**	**115**	Procedure postponed-canceled-or delayed.		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge
36	**UB Claim Form: rev code invalid this bill type, other claims place of service missing/invalid for this procedure. Correct bill type or POS and resubmit as a new claim**	**125**	Submission-billing error(s)	**M50**	Missing-incomplete-invalid revenue code(s).	**228**	Type of bill for UB claim.
36	**UB Claim Form: rev code invalid this bill type, other claims place of service missing/invalid for this procedure. Correct bill type or POS and resubmit as a new claim**	**125**	Submission-billing error(s)	**M77**	Missing-incomplete-invalid place of service(s).	**228**	Type of bill for UB claim.
36	**UB Claim Form: rev code invalid this bill type, other claims place of service missing/invalid for this procedure. Correct bill type or POS and resubmit as a new claim**	**125**	Submission-billing error(s)	**MA30**	Missing-incomplete-invalid type of bill.	**228**	Type of bill for UB claim.
36	**UB Claim Form: rev code invalid this bill type, other claims place of service missing/invalid for this procedure. Correct bill type or POS and resubmit as a new claim**	**125**	Submission-billing error(s)	**M50**	Missing-incomplete-invalid revenue code(s).	**249**	Place of service.

36	**UB Claim Form: rev code invalid this bill type, other claims place of service missing/invalid for this procedure. Correct bill type or POS and resubmit as a new claim**	**125**	Submission-billing error(s)	**M77**	Missing-incomplete-invalid place of service(s).	**249**	Place of service.
36	**UB Claim Form: rev code invalid this bill type, other claims place of service missing/invalid for this procedure. Correct bill type or POS and resubmit as a new claim**	**125**	Submission-billing error(s)	**MA30**	Missing-incomplete-invalid type of bill.	**249**	Place of service.
36	**UB Claim Form: rev code invalid this bill type, other claims place of service missing/invalid for this procedure. Correct bill type or POS and resubmit as a new claim**	**125**	Submission-billing error(s)	**M50**	Missing-incomplete-invalid revenue code(s).	**455**	Revenue code for services rendered.
36	**UB Claim Form: rev code invalid this bill type, other claims place of service missing/invalid for this procedure. Correct bill type or POS and resubmit as a new claim**	**125**	Submission-billing error(s)	**M77**	Missing-incomplete-invalid place of service(s).	**455**	Revenue code for services rendered.
36	**UB Claim Form: rev code invalid this bill type, other claims place of service missing/invalid for this procedure. Correct bill type or POS and resubmit as a new claim**	**125**	Submission-billing error(s)	**MA30**	Missing-incomplete-invalid type of bill.	**455**	Revenue 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

38	**Noncovered: Compound contains DESI drug or DESI equivalent**	**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.
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
41	**Federal Sterilization Consent Form required**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**48**	Referral-authorization.
42	**Sterilization/abortion guidelines not met**	**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.
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.
44	**Claim processed for eligible dates only**	**238**	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period		**No Mapping Required**	**20**	Accepted for processing.
44	**Claim processed for eligible dates only**	**238**	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period		**No Mapping Required**	**456**	Covered Day(s).
45	**Procedure include in Fee for Surgery**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.

45	**Procedure include in Fee for Surgery**	**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.
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.
47	**Rebill single procedure code combining service and/or multiple units and file as a new claim**	**125**	Submission-billing error(s)	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**258**	Days-units for procedure-revenue code.
47	**Rebill single procedure code combining service and/or multiple units and file as a new claim**	**125**	Submission-billing error(s)	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**476**	Missing or invalid units of service.
48	**Panel partially paid on previous claim or detail**	**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.

48	**Panel partially paid on previous claim or detail**	**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.
49	**Medical necessity is not apparent**	**50**	These are non-covered services because this is not deemed a medical necessity by the payer. 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	**N180**	This item or service does not meet the criteria for the category under which it was billed.	**287**	Medical necessity for service.
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/clinit 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.
54	**Radiation management allowed once 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.
54	**Radiation management allowed once 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
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.

57	**DME and orthotic or prosthetic equipment allowed once in 2 yrs for ages 00-20**	**108**	Rent-purchase guidelines were not met. 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	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency 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.	**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.
60	**Not in accordance with Medical 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.
61	**Full recoupment, bill Medicare**	**109**	Claim not covered by this payer-contractor. You must send the claim to the correct payer-contractor.	**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.	**585**	Denied Charge or Non-covered Charge

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.
64	**Service included in total maternity flat fee**	**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.
65	**Only provider of service may bill**	**B20**	Procedure-service was partially or fully furnished by another provider.	**N32**	Claim must be submitted by the provider who rendered the service.	**84**	Service not authorized.
66	**Duplicate payment to other provider**	**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.

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.
69	**Bill Medicare Part A 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.
70	**CAP dollar limitation has been met**	**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.
71	**Only two radiation treatments allowed in a 7 day period**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**259**	Frequency of service.
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.
74	**Rebill for services on a paper claim**	**125**	Submission-billing error(s)	**N34**	Incorrect claim form-format for this service.	**59**	Non-electronic request for information.
74	**Rebill for services on a paper claim**	**125**	Submission-billing error(s)	**N34**	Incorrect claim form-format for this service.	**277**	Paper claim.
75	**Resubmit as an adjustment and attache medical records, operative notes, federal statements or other pertinent information**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative note-report.	**294**	Supporting documentation.
75	**Resubmit as an adjustment and attache medical records, operative notes, federal statements or other pertinent information**	**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.
75	**Resubmit as an adjustment and attache medical records, operative notes, federal statements or other pertinent information**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative note-report.	**317**	Patients medical records.
75	**Resubmit as an adjustment and attache medical records, operative notes, federal statements or other pertinent information**	**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.
75	**Resubmit as an adjustment and attache medical records, operative notes, federal statements or other pertinent information**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative note-report.	**297**	Medical notes/report.

75	**Resubmit as an adjustment and attache medical records, operative notes, federal statements or other pertinent information**	**16**	Claim-service lacks information which is needed for adjudication	**N163**	Medical Record does not support code billed per the code definition.	**297**	Medical notes/report.
76	**Services not payable in advance**	**110**	Billing date predates service date.	**N301**	Missing-incomplete-invalid procedure date(s).	**510**	Future date
77	**Rebil newborn care on a separate claim and submit as a new claim**	**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.
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.
79	**This service is not payable to your provider type or specialty in accordance with Medicaid guidelines**	**170**	Payment is denied when performed-billed by this type of provider. 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	**N95**	This provider type - provider specialty may not bill this service.	**25**	Entity not approved.
80	**Units of service are not consistent with dates of service physician claims: If dates are not consecutive, list each date of service on a separate line. Correct and resubmit**	**125**	Submission-billing error(s)	**M53**	Missing-incomplete-invalid days or units of service.	**258**	Days-units for procedure-revenue code.
80	**Units of service are not consistent with dates of service physician claims: If dates are not consecutive, list each date of service on a separate line. Correct and resubmit**	**125**	Submission-billing error(s)	**N345**	Date range not valid with units submitted.	**258**	Days-units for procedure-revenue code.

81	**Procedure allowed once in 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.
82	**Service is not consistent with/or not covered for this diagnosis or description does not match diagnosis**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.
83	**Exceeds legislative limits**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N130**	**Alert-** Consult plan benefit documents for information about restrictions for this service	**259**	Frequency 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**	**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**	Entitys 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.
87	**Only 22 radiation treatments allowed in 4 weeks**	**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.
87	**Only 22 radiation treatments allowed in 4 weeks**	**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.
88	**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.
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.
90	**Duplicate charge denied**	**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.

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.
92	**Medicare supect/paid Medicaid only**	**23**	The impact of prior payer(s) adjudication including payments and-or adjustments		**No Mapping Required**	**65**	Claim-line has been paid.
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.
98	**Fee adjusted to maximum payable**	**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.
98	**Fee adjusted to maximum payable**	**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

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.
107	**Charges for sterilization 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.

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 mistatch**	**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.
126	**Rebill service using appropriate peronal habilitation 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.
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.

128	**Services not approved by 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.
129	**No patient liability on claim for partial month billing**	**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.
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.
131	**Resubmit as a new claim with operative record and/or labor & delivery record, history & physical, discharge summary, pathology report and ultrasound report**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart.	**294**	Supporting documentation.
131	**Resubmit as a new claim with operative record and/or labor & delivery record, history & physical, discharge summary, pathology report and ultrasound report**	**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.
131	**Resubmit as a new claim with operative record and/or labor & delivery record, history & physical, discharge summary, pathology report and ultrasound report**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart.	**317**	Patients medical records.

131	**Resubmit as a new claim with operative record and/or labor & delivery record, history & physical, discharge summary, pathology report and ultrasound report**	**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.
131	**Resubmit as a new claim with operative record and/or labor & delivery record, history & physical, discharge summary, pathology report and ultrasound report**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart.	**297**	Medical notes/report.
131	**Resubmit as a new claim with operative record and/or labor & delivery record, history & physical, discharge summary, pathology report and ultrasound report**	**16**	Claim-service lacks information which is needed for adjudication	**N163**	Medical record does not support code billed per the code definition.	**297**	Medical notes/report.
132	**Rebill with patient liability amount and/or correct admission date**	**125**	Submission-billing error(s)	**MA31**	Missing-incomplete-invalid beginning and ending dates of the period billed.	**189**	Facility admission date
132	**Rebill with patient liability amount and/or correct admission date**	**125**	Submission-billing error(s)	**N58**	Missing-incomplete-invalid patient liability amount.	**189**	Facility admission date
133	**Enter correct bill type in Form Locator 4 and submit as a new claim**	**125**	Submission-billing error(s)	**MA30**	Missing-incomplete-invalid type of bill.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
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.
135	**Patient status missing/not in accordance with Medicaid policy/inconsistent with days/dates billed**	**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.

135	**Patient status missing/not in accordance with Medicaid policy/inconsistent with days/dates billed**	**125**	Submission-billing error(s)	**MA43**	Missing-incomplete-invalid patient status.	**431**	Provide condition-functional status at time of service.
135	**Patient status missing/not in accordance with Medicaid policy/inconsistent with days/dates billed**	**125**	Submission-billing error(s)	**MA43**	Missing-incomplete-invalid patient status.	**90**	Entity not eligible for medical benefits for submitted dates of service. Note- This code requires use of an Entity 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.
142	**Denied-item must be obtained from state optical contractor**	**184**	The prescribing-ordering provider is not eligible to prescribe-order 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.
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.
144	**Level of care not approved for this provider number**	**185**	The rendering provider is not eligible to perform the service billed. Note- Refer to the 835 Healthcare Policy Identificaiton 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.
145	**No hysterectomy statement on file**	**16**	Claim-service lacks information which is needed for adjudication	**M127**	Missing patient medical record for this service.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
145	**No hysterectomy statement on file**	**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.
145	**No hysterectomy statement on file**	**16**	Claim-service lacks information which is needed for adjudication	**M127**	Missing patient medical record for this service.	**294**	Supporting documentation.
145	**No hysterectomy statement on file**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**294**	Supporting documentation.
145	**No hysterectomy statement on file**	**16**	Claim-service lacks information which is needed for adjudication	**M127**	Missing patient medical record for this service.	**297**	Medical notes/report.
145	**No hysterectomy statement on file**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**297**	Medical notes/report.
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.
150	**Day of discharge not covered**	**78**	Non-Covered days-Room charge adjustment.		**No Mapping Required**	**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.
153	**Ancillary charges included in per diem rate**	**125**	Submission-billing error(s)	**M2**	Not paid separately when the patient is an inpatient.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
154	**Procedure code does not allow multiple units of billings. Anesthesia provider; one unit equals 1 minute for general anesthesia TOS 07. Rebill corrected claim**	**125**	Submission-billing error(s)	**M53**	Missing-incomplete-invalid days or units of service.	**251**	Total anesthesia minutes.
154	**Procedure code does not allow multiple units of billings. Anesthesia provider; one unit equals 1 minute for general anesthesia TOS 07. Rebill corrected claim**	**125**	Submission-billing error(s)	**M53**	Missing-incomplete-invalid days or units of service.	**523**	Anesthesia Unit Count
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)
158	**This revenue code requires a CPT laboratory procedure code**	**125**	Submission-billing error(s)	**M51**	Missing-incomplete-invalid procedure code(s).	**454**	Procedure code for services rendered.
158	**This revenue code requires a CPT laboratory procedure code**	**125**	Submission-billing error(s)	**M51**	Missing-incomplete-invalid procedure code(s).	**455**	Revenue code for services rendered.
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
160	**File with Medicare**	**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.
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.

164	**PROCEDURE CODE IS NOT CONSISTENT WITH HCPC DESCRIPTION AND/OR BILLED AMOUNT. REFILE CORRECTED CLAIM OR ATTACH EXPLANATION**	**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.
164	**PROCEDURE CODE IS NOT CONSISTENT WITH HCPC DESCRIPTION AND/OR BILLED AMOUNT. REFILE CORRECTED CLAIM OR ATTACH EXPLANATION**	**125**	Submission-billing error(s)	**M51**	Missing-incomplete-invalid procedure code(s).	**454**	Procedure code for services rendered.
165	**BREAKDOWN CHARGES USING INDIVIDUAL PROCEDURE CODES**	**125**	Submission-billing error(s)	**N63**	Rebill services on separate claim lines.	**454**	Procedure code for services rendered.
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.
167	**NO CHARGE BILLED. ENTER BILLED AMOUNT AND SUBMIT DETAIL AS A NEW CLAIM**	**125**	Submission-billing error(s)	**M54**	Missing-incomplete-invalid total charges.	**178**	Submitted charges.
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.
170	**REFILE ON EPSDT CLAIM FORM**	**A1**	Claim-Service denied	**N34**	Incorrect claim form-format for this service.	**276**	UB04-HCFA-1450-1500 claim form.
170	**REFILE ON EPSDT CLAIM FORM**	**A1**	Claim-Service denied	**N34**	Incorrect claim form-format for this service.	**481**	Claim submission format is invalid.
172	**LESS THAN 3 MONTHS PRENATAL CARE APPARENTLY GIVEN: BILL APPROPRIATE ANTEPARTUM OR E&M CODE DEPENDING ON NUMBER OF VISITS**	**125**	Submission-billing error(s)	**N188**	The approved level of care does not match the procedure code submitted.	**345**	Treatment plan for service-diagnosis
172	**LESS THAN 3 MONTHS PRENATAL CARE APPARENTLY GIVEN: BILL APPROPRIATE ANTEPARTUM OR E&M CODE DEPENDING ON NUMBER OF VISITS**	**125**	Submission-billing error(s)	**N188**	The approved level of care does not match the procedure code submitted.	**306**	Detailed description of service.
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.
174	**SERVICE DATE MUST BE SAME AS BIRTHDATE WITH UNIT OF 1**	**125**	Submission-billing error(s)	**M53**	Missing-incomplete-invalid days or units of service.	**187**	Date(s) of service.

174	**SERVICE DATE MUST BE SAME AS BIRTHDATE WITH UNIT OF 1**	**125**	Submission-billing error(s)	**MA31**	Missing-incomplete-invalid beginning and ending dates of the period billed.	**187**	Date(s) of service.
175	**ADMIT HOUR REQUIRED ON OUTPAITIENT 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.
178	**PURCHASE OF VACCINE NOT INDICATED ON EPSDT CLAIM. IMMUNIZATION PAID TO DHS**	**23**	The impact of prior payer(s) adjudication including payments and-or adjustments		**No Mapping Required**	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
178	**PURCHASE OF VACCINE NOT INDICATED ON EPSDT CLAIM. IMMUNIZATION PAID TO DHS**	**23**	The impact of prior payer(s) adjudication including payments and-or adjustments		**No Mapping Required**	**107**	Processed according to contract-plan provisions.
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.
182	**ALL CLAIMS SUSPENDED PENDING FINANCIAL REVIEW. CONTACT HP PROVIDER SERVICES 1-800-688-6696**	**133**	The disposition of this claim-service is pending further review.	**N187**	**Alert-** You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	**46**	Internal review-audit.
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.
184	**ONLY ONE VISIT 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.
184	**ONLY ONE VISIT 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
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.
199	**SUBMIT AS AN ADJUSTMENT WITH HYSTERECTOMY STATEMENT, MEDICAL RECORDS TO INCLUDE H&P, OPERATIVE REPORT, PATH, SUMMARY AND CLAIM ATTACHED**	**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.
199	**SUBMIT AS AN ADJUSTMENT WITH HYSTERECTOMY STATEMENT, MEDICAL RECORDS TO INCLUDE H&P, OPERATIVE REPORT, PATH, SUMMARY AND CLAIM ATTACHED**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart.	**297**	Medical notes-report.
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.
202	**REVENUE CODE MUST BE BILLED WITH A DME-MEDICAL SUPPLY HCPC CODE**	**125**	Submission-billing error(s)	**M20**	Missing-incomplete-invalid HCPCS.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

202	**REVENUE CODE MUST BE BILLED WITH A DME-MEDICAL SUPPLY HCPC CODE**	**125**	Submission-billing error(s)	**M50**	Missing-incomplete-invalid revenue code(s)	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
202	**REVENUE CODE MUST BE BILLED WITH A DME-MEDICAL SUPPLY HCPC CODE**	**125**	Submission-billing error(s)	**M20**	Missing-incomplete-invalid HCPCS.	**507**	HCPCS
202	**REVENUE CODE MUST BE BILLED WITH A DME-MEDICAL SUPPLY HCPC CODE**	**125**	Submission-billing error(s)	**M50**	Missing-incomplete-invalid revenue code(s)	**507**	HCPCS
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
204	**PRE-MATURE DELIVERY AND-OR EMERGENCY C-SECTION MUST SHOW EDC ON THE STERILIZATION CONSENT FORM**	**125**	Submission-billing error(s)	**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.
204	**PRE-MATURE DELIVERY AND-OR EMERGENCY C-SECTION MUST SHOW EDC ON THE STERILIZATION CONSENT FORM**	**125**	Submission-billing error(s)	**N228**	Incomplete-invalid consent form	**107**	Processed according to contract-plan provisions

205	**NO UPIN ON CLAIM. REFILE WITH CORRECT UPIN**	**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.
205	**NO UPIN ON CLAIM. REFILE WITH CORRECT UPIN**	**125**	Submission-billing error(s)		**No Mapping Required**	**133**	Entitys UPIN
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.
207	**DME PROCEDURE 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.	**454**	Procedure code for services rendered.
207	**DME PROCEDURE 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.	**454**	Procedure code for services rendered.
207	**DME PROCEDURE 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.	**457**	Non-Covered Day(s)
207	**DME PROCEDURE 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.	**457**	Non-Covered Day(s)

208	**RESUBMIT FOR PRIOR APPROVED TYPE OF SERVICE**	**197**	Precertification-authorization-notification absent.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**84**	Service not authorized.
208	**RESUBMIT FOR PRIOR APPROVED TYPE OF SERVICE**	**197**	Precertification-authorization-notification absent.	**N188**	The approved level of care does not match the procedure code submitted	**84**	Service not authorized.
209	**LIMITED ORAL ECALUATION-PROBLEM FOCUSED NOT ALLOWED SAME DATE OF SERVIE AS DENTAL EXAM**	**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.
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.
211	**DATES OF SERVICE NOT WITHIN AUTHORIZED TIME PERIOD**	**197**	Precertification-authorization-notification absent.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**187**	Date(s) of service.
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.
213	**NO UPIN ON CLAIM. REFILE WITH CORRECT UPIN**	**197**	Precertification-authorization-notification absent.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**84**	Service not authorized

214	**FOLLOW UP CARE REFERRED TO OPTOMETRIST. REBILL USING CODE W9931, W9941, OR W9951; OR SUBMIT ADJUSTMENT**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
214	**FOLLOW UP CARE REFERRED TO OPTOMETRIST. REBILL USING CODE W9931, W9941, OR W9951; OR SUBMIT ADJUSTMENT**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**666**	Surgical Procedure Code
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.
216	**LAB SERVICES HAVE BEEN BILLED AND PAID TO A PATHOLOGIST OR AN INDEPENDENT LAB**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of 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.
218	**CATARACT SURGERY FOLLOW-UP INCLUDED IN FEE TO SURGEON.**	**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.

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.
220	**RESUBMIT AS AN ADJUSTMENT WITH AMBULANCE CALL REPORTS TO JUSTIFY SAME DAY ONE-WAY AND ROUNT TRIP TRANSPORTS**	**16**	Claim-service lacks information which is needed for adjudication	**N20**	Service not payable with other service rendered on the same date.	**297**	Medical notes-report.
220	**RESUBMIT AS AN ADJUSTMENT WITH AMBULANCE CALL REPORTS TO JUSTIFY SAME DAY ONE-WAY AND ROUNT TRIP TRANSPORTS**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart.	**297**	Medical notes-report.
220	**RESUBMIT AS AN ADJUSTMENT WITH AMBULANCE CALL REPORTS TO JUSTIFY SAME DAY ONE-WAY AND ROUNT TRIP TRANSPORTS**	**16**	Claim-service lacks information which is needed for adjudication	**N56**	Procedure code billed is not correct-valid for the services billed or the date of service billed.	**297**	Medical notes-report.
220	**RESUBMIT AS AN ADJUSTMENT WITH AMBULANCE CALL REPORTS TO JUSTIFY SAME DAY ONE-WAY AND ROUNT TRIP TRANSPORTS**	**16**	Claim-service lacks information which is needed for adjudication	**N20**	Service not payable with other service rendered on the same date.	**337**	Ambulance certification-documentation.

220	**RESUBMIT AS AN ADJUSTMENT WITH AMBULANCE CALL REPORTS TO JUSTIFY SAME DAY ONE-WAY AND ROUNT TRIP TRANSPORTS**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart.	**337**	Ambulance certification-documentation.
220	**RESUBMIT AS AN ADJUSTMENT WITH AMBULANCE CALL REPORTS TO JUSTIFY SAME DAY ONE-WAY AND ROUNT TRIP TRANSPORTS**	**16**	Claim-service lacks information which is needed for adjudication	**N56**	Procedure code billed is not correct-valid for the services billed or the date of service billed.	**337**	Ambulance certification-documentation.
220	**RESUBMIT AS AN ADJUSTMENT WITH AMBULANCE CALL REPORTS TO JUSTIFY SAME DAY ONE-WAY AND ROUNT TRIP TRANSPORTS**	**16**	Claim-service lacks information which is needed for adjudication	**N20**	Service not payable with other service rendered on the same date.	**472**	Ambulance Run Sheet
220	**RESUBMIT AS AN ADJUSTMENT WITH AMBULANCE CALL REPORTS TO JUSTIFY SAME DAY ONE-WAY AND ROUNT TRIP TRANSPORTS**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart.	**472**	Ambulance Run Sheet
220	**RESUBMIT AS AN ADJUSTMENT WITH AMBULANCE CALL REPORTS TO JUSTIFY SAME DAY ONE-WAY AND ROUNT TRIP TRANSPORTS**	**16**	Claim-service lacks information which is needed for adjudication	**N56**	Procedure code billed is not correct-valid for the services billed or the date of service billed.	**472**	Ambulance Run Sheet
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.

222	**RECIPIENT NAME ON FILE IS NOT THE SAME AS ON THE STATEMENT/CONSENT. ATTACH NOTE OF VERIFICATION TO STATEMENT/CONSENT THAT THIS IS THE SAME PERSON AND RESUBMIT**	**16**	Claim-service lacks information which is needed for adjudication	**MA36**	Missing-incomplete-invalid patient name	**31**	Subscriber and policyholder name mismatched
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.
224	**FOLLOW-UP VISITS AND CONSULTS NOT ALLOWED SAME DAY AS DIALYSIS TREATMENT**	**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.
225	**GROUP-OUTPATIENT TX NOT ALLOWED SAME DOS AS HOSPITAL GROUP THERAPY/MEDICATION ADMINISTRATION**	**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.

226	**THE HYSTERECTOMY STATEMENT DOES NOT MEET FEDERAL GUIDELINES, RESUBMIT A COMPLETED NEW 'PRIOR TO MY SURGERY' STATEMENT**	**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.
226	**THE HYSTERECTOMY STATEMENT DOES NOT MEET FEDERAL GUIDELINES, RESUBMIT A COMPLETED NEW 'PRIOR TO MY SURGERY' STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**297**	Medical notes/report.
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.
228	**SERVICE INCLUDED IN PREVIOUSLY PAID CYSTOURETHROSCOPY 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.
229	**PREVIOUSLY PAID PROCEDURE 52005 IS INCLUDED IN THIS SERVICE, PLEASE FILE AN ADJUSTMENT**	**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.

229	**PREVIOUSLY PAID PROCEDURE 52005 IS INCLUDED IN THIS SERVICE, PLEASE FILE AN ADJUSTMENT**	**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.	**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	**454**	Procedure code for services rendered.
230	**PREVIOUSLY PAID PROCEDURE 52000 IS INCLUDED IN THIS SERVICE, PLEASE FILE AN ADJUSTMENT**	**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.
230	**PREVIOUSLY PAID PROCEDURE 52000 IS INCLUDED IN THIS SERVICE, PLEASE FILE AN ADJUSTMENT**	**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.	**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	**454**	Procedure code for services rendered.
231	**SAIOP IS NOT ALLOWED AME DOS AS PARTIAL HOSPITALIZATION AND/OR DAY TREATMENT**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service
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.
234	**CASE MANAGEMENT NOT ALLOWED SAME DAY AS ADJULT CHRONICALLY MENTALLY ILL, CHILD EMOTIONALLY DISTURBED, SUBSTANCE ABUSE OR WILLIE M**	**B15**	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. 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.
235	**SERVUCE DENIED, RECIPIENTS SIGNATURE AND-OR SIGNATURE DATE ON STERILIZATION CONSENT FORM HAS BEEN ALTERED**	**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.
235	**SERVUCE DENIED, RECIPIENTS SIGNATURE AND-OR SIGNATURE DATE ON STERILIZATION CONSENT FORM HAS BEEN ALTERED**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**468**	Patient signature source.
235	**SERVUCE DENIED, RECIPIENTS SIGNATURE AND-OR SIGNATURE DATE ON STERILIZATION CONSENT FORM HAS BEEN ALTERED**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**492**	Other Procedure Date.

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 SUME 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 SUME 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.
239	**FOLLOW-UP VISITS OR CONSULTS TO BE RECOUPED. FOLLOW-UP VISIT OR CONSULT NOT ALLOWED SAME DATE OF SERVICE AS DIALYSIS TREATMENT**	**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.
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

241	**UPIN ON CLAIM NOT A VALID UPIN. CONTACT PRESCRIBER AND REFILE CLAIM WITH CORRECT UPIN**	**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.
241	**UPIN ON CLAIM NOT A VALID UPIN. CONTACT PRESCRIBER AND REFILE CLAIM WITH CORRECT UPIN**	**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.
241	**UPIN ON CLAIM NOT A VALID UPIN. CONTACT PRESCRIBER AND REFILE CLAIM WITH CORRECT UPIN**	**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.	**133**	Entitys UPIN
241	**UPIN ON CLAIM NOT A VALID UPIN. CONTACT PRESCRIBER AND REFILE CLAIM WITH CORRECT UPIN**	**125**	Submission-billing error(s)	**N31**	Missing-incomplete-invalid prescribing provider identifier	**133**	Entitys UPIN
242	**DME SERVICE PAID ONLY TO DME ENROLLED PROVIDERS**	**184**	The prescribing-ordering provider is not eligible to prescribe-order the service billed. 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	**N95**	This provider type - provider specialty may not bill this service.	**91**	Entity not eligible-not approved for dates of service.

243	**ULTRA SOUND PREVIOUSLY PADI IN HX FOR THIS DOS. IF THIS IS A SECOND ULTRA SOUND SUBMIT AS ADJ. WITH DOCUMENTATION**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
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.
245	**STERILIZATION FORM MISSING/INCOMPLETE**	**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.
247	**RECORDS INDICATE EPIDURAL PROCEDURE PERFORMED, PLEASE RECODE AND RESUBMIT**	**125**	Submission-billing error(s)	**N163**	Medical record does not support code billed per the code definition	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
247	**RECORDS INDICATE EPIDURAL PROCEDURE PERFORMED, PLEASE RECODE AND RESUBMIT**	**125**	Submission-billing error(s)	**N163**	Medical record does not support code billed per the code definition	**454**	Procedure code for services rendered

248	**REFILE AS ADJ. WITH DOCUMENTATION OF SECOND ULTRA SOUND PROCEDURE BEING PERFORMED SAME DATE OF SERVICE**	**16**	Claim-service lacks information which is needed for adjudication	**M51**	Missing-incomplete-invalid procedure code(s).	**101**	Claim was processed as adjustment to previous claim.
248	**REFILE AS ADJ. WITH DOCUMENTATION OF SECOND ULTRA SOUND PROCEDURE BEING PERFORMED SAME DATE OF SERVICE**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes- summary- report- chart.	**101**	Claim was processed as adjustment to previous claim.
250	**OVER 6 HOURS OF CRITICAL CARE BILLED FOR SAME DATE OF SERVICE. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION OF TIME (I.E., ICU RECORD, PHYSICIAN PROGRESS NOES)**	**16**	Claim-service lacks information which is needed for adjudication	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**187**	Date(s) of service.
250	**OVER 6 HOURS OF CRITICAL CARE BILLED FOR SAME DATE OF SERVICE. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION OF TIME (I.E., ICU RECORD, PHYSICIAN PROGRESS NOES)**	**16**	Claim-service lacks information which is needed for adjudication	**N393**	Missing progress notes-report.	**187**	Date(s) of service.
250	**OVER 6 HOURS OF CRITICAL CARE BILLED FOR SAME DATE OF SERVICE. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION OF TIME (I.E., ICU RECORD, PHYSICIAN PROGRESS NOES)**	**16**	Claim-service lacks information which is needed for adjudication	**N435**	Exceeds number-frequency approved -allowed within time period without support documentation.	**187**	Date(s) of service.

250	**OVER 6 HOURS OF CRITICAL CARE BILLED FOR SAME DATE OF SERVICE. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION OF TIME (I.E., ICU RECORD, PHYSICIAN PROGRESS NOES)**	**16**	Claim-service lacks information which is needed for adjudication	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
250	**OVER 6 HOURS OF CRITICAL CARE BILLED FOR SAME DATE OF SERVICE. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION OF TIME (I.E., ICU RECORD, PHYSICIAN PROGRESS NOES)**	**16**	Claim-service lacks information which is needed for adjudication	**N393**	Missing progress notes-report.	**259**	Frequency of service.
250	**OVER 6 HOURS OF CRITICAL CARE BILLED FOR SAME DATE OF SERVICE. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION OF TIME (I.E., ICU RECORD, PHYSICIAN PROGRESS NOES)**	**16**	Claim-service lacks information which is needed for adjudication	**N435**	Exceeds number-frequency approved -allowed within time period without support documentation.	**259**	Frequency of service.
250	**OVER 6 HOURS OF CRITICAL CARE BILLED FOR SAME DATE OF SERVICE. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION OF TIME (I.E., ICU RECORD, PHYSICIAN PROGRESS NOES)**	**16**	Claim-service lacks information which is needed for adjudication	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**294**	Supporting documentation.

250	**OVER 6 HOURS OF CRITICAL CARE BILLED FOR SAME DATE OF SERVICE. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION OF TIME (I.E., ICU RECORD, PHYSICIAN PROGRESS NOES)**	**16**	Claim-service lacks information which is needed for adjudication	**N393**	Missing progress notes-report.	**294**	Supporting documentation.
250	**OVER 6 HOURS OF CRITICAL CARE BILLED FOR SAME DATE OF SERVICE. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION OF TIME (I.E., ICU RECORD, PHYSICIAN PROGRESS NOES)**	**16**	Claim-service lacks information which is needed for adjudication	**N435**	Exceeds number-frequency approved -allowed within time period without support documentation.	**294**	Supporting documentation.
251	**RESUBMIT AS AN ADJUSTMENT WITH ANESTHESIA RECORDS**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart	**262**	Type of surgery-service for which anesthesia was administered.
251	**RESUBMIT AS AN ADJUSTMENT WITH ANESTHESIA RECORDS**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart	**294**	Supporting documentation
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.
254	**X-RAY W/O CONTRAST NOT ALLOWED SAME DOS AS NON-IONIC CONTRAST MEDIA**	**16**	Claim-service lacks information which is needed for adjudication	**N202**	Additional information-explanation will be sent separately	**101**	Claim was processed as adjustment to previous claim.
255	**PLEASE INDICATE OR CORRECT THE NUMBER OF CO-INS OR LIFETIME RESERVE DAYS BILLED TO CORRESPOND WITH MONIES ON THE VOUCHER AND RESUBMIT AS A NEW CLAIM**	**23**	The impact of prior payer(s) adjudication including payments and-or adjustments	**MA34**	Missing-incomplete-invalid number of coinsurance days during the billing period.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
255	**PLEASE INDICATE OR CORRECT THE NUMBER OF CO-INS OR LIFETIME RESERVE DAYS BILLED TO CORRESPOND WITH MONIES ON THE VOUCHER AND RESUBMIT AS A NEW CLAIM**	**23**	The impact of prior payer(s) adjudication including payments and-or adjustments	**MA35**	Missing-incomplete-invalid number of lifetime reserve days.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
255	**PLEASE INDICATE OR CORRECT THE NUMBER OF CO-INS OR LIFETIME RESERVE DAYS BILLED TO CORRESPOND WITH MONIES ON THE VOUCHER AND RESUBMIT AS A NEW CLAIM**	**23**	The impact of prior payer(s) adjudication including payments and-or adjustments	**MA34**	Missing-incomplete-invalid number of coinsurance days during the billing period.	**458**	Coinsurance Day(s).

255	**PLEASE INDICATE OR CORRECT THE NUMBER OF CO-INS OR LIFETIME RESERVE DAYS BILLED TO CORRESPOND WITH MONIES ON THE VOUCHER AND RESUBMIT AS A NEW CLAIM**	**23**	The impact of prior payer(s) adjudication including payments and-or adjustments	**MA35**	Missing-incomplete-invalid number of lifetime reserve days.	**458**	Coinsurance Day(s).
255	**PLEASE INDICATE OR CORRECT THE NUMBER OF CO-INS OR LIFETIME RESERVE DAYS BILLED TO CORRESPOND WITH MONIES ON THE VOUCHER AND RESUBMIT AS A NEW CLAIM**	**23**	The impact of prior payer(s) adjudication including payments and-or adjustments	**MA34**	Missing-incomplete-invalid number of coinsurance days during the billing period.	**459**	Lifetime Reserve Day(s)
255	**PLEASE INDICATE OR CORRECT THE NUMBER OF CO-INS OR LIFETIME RESERVE DAYS BILLED TO CORRESPOND WITH MONIES ON THE VOUCHER AND RESUBMIT AS A NEW CLAIM**	**23**	The impact of prior payer(s) adjudication including payments and-or adjustments	**MA35**	Missing-incomplete-invalid number of lifetime reserve days.	**459**	Lifetime Reserve Day(s)
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
258	**ADJUSTMENT REFERRED TO DMA FOR ELIGIBILITY DETERMINATION. DON NOT RESUBMIT**	**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.	**258**	Days-units for procedure-revenue code.
258	**ADJUSTMENT REFERRED TO DMA FOR ELIGIBILITY DETERMINATION. DON NOT RESUBMIT**	**133**	The disposition of this claim-service is pending further review.	**N185**	**Alert-** Do not resubmit this claim-service	**258**	Days-units for procedure-revenue code.
259	**NON-IONIC CONTRAST MEDIA ALLOWED 4 UNITS 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.
259	**NON-IONIC CONTRAST MEDIA ALLOWED 4 UNITS PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
259	**NON-IONIC CONTRAST MEDIA ALLOWED 4 UNITS 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
259	**NON-IONIC CONTRAST MEDIA ALLOWED 4 UNITS PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount

260	**NON-IONIC CONTRAST MEDIA ALLOWED SAME DOS AS X-RAY W/O CONTRAST**	**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.
261	**REMOVAL AND INSERTION OF NORPLANT SYSTEM INCLUED IN PROCEDURE W5133**	**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.
262	**PROCEDURE INCLUDES FEE FOR REMOVAL AND INSERTION OF NORPLANT SYSTEM**	**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.
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.
264	**ADJUSTMENT DENIED, CLAIM DENIED CORRECTLY**	**A1**	Claim-Service denied	**MA91**	This determination is the result of the appeal you filed.	**101**	Claim was processed as adjustment to previous claim.

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.
270	**BILLING PROVIDER IS NOT THE RECIPIENT'S CAROLINA ACCESS PCP. AUTHORIZATION IS MISSING OR UNRESOLVED. CONTACT PCP FOR AUTHORIZATION OR HP PROV SVCS IF AUTHORIZATION IS CORRECT**	**242**	Services not provided by network-primary care providers	**N52**	Patient not enrolled in the billing providers managed care plan on the date of service.	**93**	Entity is not selected primary care provider.

270	**BILLING PROVIDER IS NOT THE RECIPIENT'S CAROLINA ACCESS PCP. AUTHORIZATION IS MISSING OR UNRESOLVED. CONTACT PCP FOR AUTHORIZATION OR HP PROV SVCS IF AUTHORIZATION IS CORRECT**	**242**	Services not provided by network-primary care providers	**N52**	Patient not enrolled in the billing providers managed care plan on the date of service.	**252**	Authorization-certification number.
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.
			Appeal procedures not followed or				

274	**FULL RECOUPMENT, RESUBMIT AS NEW DAY CLAIM**	**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.
276	**FULL RECOUPMENT PER DMA MEMO**	**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.
279	**NO PATIENT LIABILITY ON ELIG FILE**	**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.
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.
282	**PATIENT STATUS MISSING OR INVALID**	**125**	Submission-billing error(s)	**MA43**	Missing-incomplete-invalid patient status.	**18**	Entity received claim-encounter, but returned invalid status.

282	**PATIENT STATUS MISSING OR INVALID**	**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.
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.
286	**INCORRECT AUTHORIZATION NUMBER ON CLAIM FORM. VERIFY NUMBER AND REFILE**	**165**	Referral absent or exceeded	**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.	**252**	Authorization-certification number.
286	**INCORRECT AUTHORIZATION NUMBER ON CLAIM FORM. VERIFY NUMBER AND REFILE**	**165**	Referral absent or exceeded	**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

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 COMMERICAL 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
289	**EMERGENCY AUTHORIZATION NOT VALID FOR CAROLINA ACCESS RECIPIENT**	**197**	Precertification-authorization-notification absent.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**25**	Entity not approved.
289	**EMERGENCY AUTHORIZATION NOT VALID FOR CAROLINA ACCESS RECIPIENT**	**197**	Precertification-authorization-notification absent.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**48**	Referral-authorization.
290	**RC CODE DOES NOT MATCH DME PRIOR APPROVAL NUMBER**	**197**	Precertification-authorization-notification absent.	**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.
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.

299	**PAYMENT DENIED, NO DOCUMENTATION OF SERVICES RENDERED**	**150**	Payer deems the information submitted does not support this level of service	**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.
299	**PAYMENT DENIED, NO DOCUMENTATION OF SERVICES RENDERED**	**150**	Payer deems the information submitted does not support this level of service	**N29**	Missing documentation-orders-notes-summary-report-chart.	**294**	Supporting documentation.
300	**TIME BILLED IS NOT SUBSTANTIATED BY MEDICAL RECORDS. TIME-UNITS REDUCED TO MATCH TIME DOCUMENTED (UP TO 3 HOURS)**	**152**	Payer deems the information submitted does not support this length of service. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**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.
300	**TIME BILLED IS NOT SUBSTANTIATED BY MEDICAL RECORDS. TIME-UNITS REDUCED TO MATCH TIME DOCUMENTED (UP TO 3 HOURS)**	**152**	Payer deems the information submitted does not support this length of service. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**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.	**476**	Missing or invalid units of service
301	**PHYSICIAN VISIT NOT ALLOWED SAME DAY AS HEALTH CHECK SCREEN BY SAME PROVIDER OR MEMBER OF SAME GROUP. RESUBMIT AS AN ADJUSTMENT WITH DOUCMENTATION SUPPORTING RELATED SERVICES**	**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. .

301	**PHYSICIAN VISIT NOT ALLOWED SAME DAY AS HEALTH CHECK SCREEN BY SAME PROVIDER OR MEMBER OF SAME GROUP. RESUBMIT AS AN ADJUSTMENT WITH DOUCMENTATION SUPPORTING RELATED SERVICES**	**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.	**294**	Supporting documentation
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.
303	**INITIAL RELINE OR ADJUSTMENT OF PARTIAL UPPER DENTURES NOT ALLOWED UNTIL 6 MONTHS AFTER RECEIPT OF DENTURES 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.	**259**	Frequency of service.
304	**INITIAL RELINE OR ADJUSTMENT OF PARTIAL UPPER DENTURES NOT ALLOWED UNTIL 6 MONTHS AFTER RECEIPT OF DENTURES 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.	**259**	Frequency of service.

305	**PANOREX NOT ALLOWED IN CONJUNCTION WITH FULL MOUTH SERIES**	**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.
306	**CORE BUILDUP, PIN RETENTION, AND COMPOSIT OR AMALGAM BUILD-UP NOT ALLOWED ON THE SAME DATE OF SERVICE**	**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.
307	**INITIAL RELINE OR ADJUSTMENT OF COMPLETE LOWER DENTURES NOT ALLOWED UNTIL 6 MONTHS AFTER RECEIPT OF DENTURES 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.	**259**	Frequency of service.
308	**Related Service on same day as Health Check screen not supported by diagnosis.**	**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.	**M76**	Missing-incomplete-invalid diagnosis or condition.	**258**	Days-units for procedure-revenue code.

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.
310	**HOSPITAL AND PSYCHIATRIC VISITS NOT ALLOWED ON THE SAME DATE OF SERVICE**	**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.	**M22**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
311	**INITIAL RELINE OR ADJUSTMENT OF PARTIAL LOWER DENTURES NOT ALLOWED UNTIL 6 MONTHS AFTER RECEIPT OF DENTURES 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.	**259**	Frequency of service.
312	**SURGERY FEE INCLUDES CHARGES FOR CASTING/BRACING**	**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.

313	**SURGERY FEE INCLUDES CAST FEE**	**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.
314	**SURGERY FEE INCLUDES CAST FEE**	**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.
315	**SURGERY FEE INCLUDES CAST FEE**	**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.
316	**SPECIAL SERVICES DENIED, CIRCUMSTANCES FOR USE OF THIS PROCEDURE-MODIFIER COMBINATION ARE NOT SUBSTANTIATED ON THE CLAIM-RECORDS**	**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.
316	**SPECIAL SERVICES DENIED, CIRCUMSTANCES FOR USE OF THIS PROCEDURE-MODIFIER COMBINATION ARE NOT SUBSTANTIATED ON THE CLAIM-RECORDS**	**125**	Submission-billing error(s)	**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.

316	**SPECIAL SERVICES DENIED, CIRCUMSTANCES FOR USE OF THIS PROCEDURE-MODIFIER COMBINATION ARE NOT SUBSTANTIATED ON THE CLAIM-RECORDS**	**125**	Submission-billing error(s)	**N188**	The approved level of care does not match the procedure code submitted.	**453**	Procedure Code modifier(s) for service(s) rendered.
316	**SPECIAL SERVICES DENIED, CIRCUMSTANCES FOR USE OF THIS PROCEDURE-MODIFIER COMBINATION ARE NOT SUBSTANTIATED ON THE CLAIM-RECORDS**	**125**	Submission-billing error(s)	**N225**	Incomplete-invalid documentation-orders-notes-summary-report-chart	**453**	Procedure Code modifier(s) for service(s) rendered.
317	**FILE ADJUSTMENT USING CBC CODE THAT INCLUDES ALL COMPONENTS BILLED AND COMBINE CHARGES**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
318	**INITIAL AND OR ESTABLISHED OFFICE VISIT INCLUDED IN FEE FOR SERVICE. RESUBMIT AS AN ADJUSTMENT**	**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.
318	**INITIAL AND OR ESTABLISHED OFFICE VISIT INCLUDED IN FEE FOR SERVICE. RESUBMIT AS AN ADJUSTMENT**	**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.	**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	**454**	Procedure code for services rendered.

319	**POINT OF ORIGIN CODE SUBMITTED IS MISSING OR IS NOT IN ACCORDANCE WITH MEDICAID POLICY. REBILL WITH CORRECT SOURCE OF ADMISSION COE. REFER TO UB MANUAL**	**125**	Submission-billing error(s)	**MA42**	Missing-incomplete-invalid admission source.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
319	**POINT OF ORIGIN CODE SUBMITTED IS MISSING OR IS NOT IN ACCORDANCE WITH MEDICAID POLICY. REBILL WITH CORRECT SOURCE OF ADMISSION COE. REFER TO UB MANUAL**	**125**	Submission-billing error(s)	**MA42**	Missing-incomplete-invalid admission source.	**229**	Hospital admission source.
320	**PSYCHIATRIC AND HOSPITAL VISITS NOT ALLOWED ON THE 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.	**M22**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
321	**USE 99025 IF BILLING ESTAB OFF VISIT OR FOLLOW-UP CONSULT W AND ASTERISK SURGICAL PROCEDURE. IF BILLING INPAT OR OUTPAT CONSULT W ASTERISK SURGICAL PROCEDURE, SUBMIT ADJUSTMENT**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

322	**TOTAL OB PACKAGE PAID. ROUTINE OFFICE VISITS, LABS OR CONSULTATIONS INCLUDED IN TOTAL OB PACKAGE WILL BE RECOUPED**	**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.
323	**HOSPITAL/OFFICE VISITS NOT ALLWED SAME DATE OF SERVICE**	**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.	**M22**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
324	**OFFICE/HOSPITAL VISITS NOT ALLOWED SAME DATE OF SERVICE**	**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.	**M22**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
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.
326	**A VALID DATE OF DENIAL MUST ACCOMPANY OCCURRENCE CODE 24. CORRECT 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.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
326	**A VALID DATE OF DENIAL MUST ACCOMPANY OCCURRENCE CODE 24. CORRECT 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.	**721**	NUBC Occurrence Span Code(s)
326	**A VALID DATE OF DENIAL MUST ACCOMPANY OCCURRENCE CODE 24. CORRECT 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.	**722**	NUBC Occurrence Span Code Date(s)
327	**CODE MULTPLE 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.

328	**CODE MULTIPLE LAB TEST CODES ON 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.
329	**PRIOR TO 6-1-93, ONLY ONE MODALITY IS 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.
329	**PRIOR TO 6-1-93, ONLY ONE MODALITY IS 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.	**442**	Modalities of service.
329	**PRIOR TO 6-1-93, ONLY ONE MODALITY IS 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
330	**MISCELLANEOUS CHARGES NOT ALLOWED WITH PROLONGED SERVICES OR CRITICAL CARE**	**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.
331	**PRIOR TO 6-1-93, EACH ADDITIONAL PHYSICAL MEDICINE TREATMENT IS NOT ALLOWED WITH MODALITIES**	**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.

331	**PRIOR TO 6-1-93, EACH ADDITIONAL PHYSICAL MEDICINE TREATMENT IS NOT ALLOWED WITH MODALITIES**	**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.	**442**	Modalities of service.
332	**EEG/ECG/EKG RECORDINGS INCLUDED IN CIRCADIAN RESPIRATORY**	**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.
333	**MACHINE CHARGE DENIED-HOSPITAL OWNED EQUIP**	**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.
334	**INITIAL/ESTABLISHED OFF VIS 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.

335	**CULDOSCOPY WITH BIPSY INCLUDED IN COLPOSCOPY WITH BIOPSY**	**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.
336	**PHYSICIAN OWNED EQUIPMENT-MACHINE CHARGE DENIED**	**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.
337	**CRITICAL CARE AND ICU FOLLOW-UP 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.
338	**BIOPSY OF CERVIX INCLUDED IN COLPOSCOPY/CULDOSCOPY**	**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.

339	**ICU FOLLOW-UP AND CRITICL CARE 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.
340	**DILATION OF CERVICAL CANAL/DILATION AND CURRETTAGE INCLUDED INBIOPSY OF CERVIX, CIRCUMFERENTIAL CONE WITH OR WITHOUT DILATION AND CURRETTAGE**	**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.
341	**HEALTH CHECK SCREEN NOT ALLOWED ON SAME DAY AS RELATED SERVICE BY THE SAME OR DIFFERENT HEALTH DEPARTMENT**	**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.
342	**DACRYOCYSTOGRAPHY INCLUDES INJECTION OF CONTRAST MEDIUM**	**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.

343	**COLPOSCOPY-CULDOSCOPY INCLUDES BIOPSY. RESUMBIT AS AN ADJUSTMENT**	**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.
343	**COLPOSCOPY-CULDOSCOPY INCLUDES BIOPSY. RESUMBIT AS AN ADJUSTMENT**	**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.	**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	**454**	Procedure code for services rendered.
344	**USE ESTABLISHED EYE EXAM CODE**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
345	**CHARGES FOR CASTING/BRACING IS INCLUDED IN SURGERY FEE**	**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.
346	**CHARGES FOR CAST INCLUDED IN SURGERY FEE**	**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.

347	**CHARGES FOR CAST INCLUDED IN SURGERY FEE**	**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.
348	**CHARGES FOR CAST INCLUDED IN SURGERY FEE**	**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.
349	**HEALTH CHECK SCREEN AND RELATED SERVICE NOT ALLOWED SAME DAY, SAME PROVIDER OR MEMBER OF SAME GROUP. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION SUPPORTING RELATED SERVICES**	**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).	**258**	Days-units for procedure-revenue code.
349	**HEALTH CHECK SCREEN AND RELATED SERVICE NOT ALLOWED SAME DAY, SAME PROVIDER OR MEMBER OF SAME GROUP. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION SUPPORTING RELATED SERVICES**	**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.

350	**DAILY AND/OR WEEKLY COBALT THERAPY CANNOT BE BILLED IN DUPLICATE**	**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.
351	**PROPHYLAXIS WITH FLUORIDE FEE INCLUDES PROPHYLAXIS CHARGESPROLONHGED**	**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.
352	**CHEMONUCLEOLYSIS AND LAMINECTOMY CANNOT BE BILLED WITHIN ONE YEAR OF EACH OTHER**	**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.
352	**CHEMONUCLEOLYSIS AND LAMINECTOMY CANNOT BE BILLED WITHIN ONE YEAR OF EACH OTHER**	**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.
353	**ANTEPARTUM, PACKAGE CAN BE BILLED ONLY ONCE IN 300 DAYS PRIOR TO DELIVERY. LABORATORY WORK IS INCLUDED IN PACKAGE FEE**	**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.	**259**	Frequency of service.
353	**ANTEPARTUM, PACKAGE CAN BE BILLED ONLY ONCE IN 300 DAYS PRIOR TO DELIVERY. LABORATORY WORK IS INCLUDED IN PACKAGE FEE**	**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.

354	**HOME PHOTO THERAPY UNIT ALLOWED ONCE WEEKLY**	**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.
354	**HOME PHOTO THERAPY UNIT ALLOWED ONCE WEEKLY**	**119**	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.
355	**PROLONGED SERVICES AND CRIT CARE NOT ALLOWED WITH DAILY CARE OR MISC CHARGES**	**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.
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**	Entitys National Provider Identifier (NPI)
357	**MATERNITY CHARGE ALLOWED ONLY ONCE PER GESTATION PERIOD. RESUBMIT AS AN ADJUSTMENT WITH MEDICAL RECORDS TO SUPPORT MULTIPLE/REOCCURRING GESTATION**	**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.

357	**MATERNITY CHARGE ALLOWED ONLY ONCE PER GESTATION PERIOD. RESUBMIT AS AN ADJUSTMENT WITH MEDICAL RECORDS TO SUPPORT MULTIPLE/REOCCURRING GESTATION**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N435**	Exceeds number-frequency approved -allowed within time period without support documentation.	**259**	Frequency of service.
358	**ONLY ONE NAIL DEBRIDEMENT ALLOWED/60 DAY 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.
359	**INDIVIDUAL COMPONENTS RECOUPED. HEMATOLOGY PANEL THAT INCLUDES COMPONENTS ALREADY PAID**	**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.
360	**CARBON DIOXIDED DETERMINATION 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.
361	**LABS INLCUDED IN ADULT HEALTH SCREENING**	**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.

362	**BITEWINGS ALREADY BILLED WITHIN 364 DAYS NOT AS COMPONENTS OF A FULL MOUTH SURVEY**	**119**	Benefit maximum for this time period has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
362	**BITEWINGS ALREADY BILLED WITHIN 364 DAYS NOT AS COMPONENTS OF A FULL MOUTH SURVEY**	**119**	Benefit maximum for this time period has been reached.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**259**	Frequency of service.
362	**BITEWINGS ALREADY BILLED WITHIN 364 DAYS NOT AS COMPONENTS OF A FULL MOUTH SURVEY**	**119**	Benefit maximum for this time period 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.
362	**BITEWINGS ALREADY BILLED WITHIN 364 DAYS NOT AS COMPONENTS OF A FULL MOUTH SURVEY**	**119**	Benefit maximum for this time period 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.
363	**NOT IN ACCORDACE WITH MEDICAL 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.
364	**NOT IN ACCORDACE WITH MEDICAL 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.
365	**OFFICE VISIT AND/OR CONSULTATIONS ARE INCLUDED IN EYE EXAM**	**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.

366	**DELIVERY (WITH OR WITHOUT POSTPARTUM CARE) IS INCLUDED IN TOTAL OB PACKAGE**	**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.
367	**SEMEN ANALYSIS INCLUDED IN FEE FOR STERILIZATION**	**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.
368	**MULTIPLE CONSULTATIONS NOT ALLOWED SAME DOS, SAME PROVIDER SPECIALTY**	**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.
369	**MULTIPLE OFFICE VISITS NOT ALLOWED SAME DOS, SAME PROVIDER SPECIALTY**	**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.

370	**MULTIPLE HOSPITAL VISITS NOT ALLOWED SAME DOS, SAME PROVIDER SPECIALTY**	**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.
371	**SUPPLIES NOT ALLOWED WITH HEALTH CHECK FEE**	**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.
372	**ONE SUPPLY ALLOWED PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
372	**ONE SUPPLY ALLOWED PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
373	**CONSULTS AND HOSPITAL VISITS NOT ALLOWED SAME DOS, SAME PROVIDER SPECIALTY**	**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.	**M22**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.

374	**CONSULTS AND OFFICE VISITS NOT ALLOWED SAME DOS, SAME PROVIDER SPECIALTY**	**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.
375	**EXPLORATORY LAPAROTOMY INCLUDED IN FEE FOR SURGERY**	**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.
376	**ROUTINE LABS INCLUDED IN DIALYSIS FEES**	**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.
377	**ROUTINE LABS INCLUDED IN DIALYSIS FEES**	**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.

378	**PROFESSIONAL MONTHLY FEE NOT ALLOWED WITH RETRAINING FEE**	**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.
379	**HISTORY SHOWS TOTAL OB PACKAGE BILLED WHICH INCLUDES LABS CONSULTATIONS AND OFFICE VISITS**	**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.
380	**SUPPLIES NOT ALLOWED WITH HEALTH CHECK FEE**	**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.
381	**HEALTH CHECK REIMBURSEMENT NOT ALLOWED ON SAME DAY OF SERVICE AS SUPPLIES PAID PREVIOUSLY**	**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.

382	**OPERATIVE RECORDS RECEIVED HAVE NO DOS-OR CONFLICTING DOS, CORRECT CLAIM/RECORDS AND RESUBMIT BOTH AS AN ADJUSTMENT**	**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.
382	**OPERATIVE RECORDS RECEIVED HAVE NO DOS-OR CONFLICTING DOS, CORRECT CLAIM/RECORDS AND RESUBMIT BOTH AS AN ADJUSTMENT**	**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.	**187**	Date(s) of service.
382	**OPERATIVE RECORDS RECEIVED HAVE NO DOS-OR CONFLICTING DOS, CORRECT CLAIM/RECORDS AND RESUBMIT BOTH AS AN ADJUSTMENT**	**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.	**298**	Operative report.
383	**SALPINGO-OOPHORECTOMY INCLUDED IN HYSTERECTOMY CODE. RESUBMIT AS AN ADJUSTMENT WITH APPROPRIATE MEDICAL RECORDS**	**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.	**287**	Medical necessity for service.
383	**SALPINGO-OOPHORECTOMY INCLUDED IN HYSTERECTOMY CODE. RESUBMIT AS AN ADJUSTMENT WITH APPROPRIATE MEDICAL RECORDS**	**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.	**294**	Supporting documentation.

383	**SALPINGO-OOPHORECTOMY INCLUDED IN HYSTERECTOMY CODE. RESUBMIT AS AN ADJUSTMENT WITH APPROPRIATE MEDICAL RECORDS**	**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.
384	**CIRCADIAN RESPIRATORY PATTERN INCLUDES EEG, ECG, AND EKG RECORDINGS. RESUBMIT AS AN ADJUSTMENT**	**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.
385	**I&D INCLUDED IN APPENDECTOMY**	**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.
386	**OFFICE VISIT /CONSULT ALREADY PAID IN HISTORY. RESUBMIT AS AN ADJUSTMENT**	**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.
387	**DAILY AND/OR WEEKLY COBALT THERAPY CANNOT BE BILLED IN DUPLICATE**	**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.

388	**PERIODONTAL SCALING AND ROOT PLANING, FULL MOUT DEBRIDEMENT TO ENABLE COMPREHENSIVE PERIODONTAL EVAL AND DX, AND PERIODONTAL MAINTENANCE INLCUDE IN FEE FOR PERIODONTAL SURGERY**	**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.
389	**ADULT HEALTH SCREENING INCLUDES LABS, RESUBMIT AS AN ADJUSTMENT**	**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.
389	**ADULT HEALTH SCREENING INCLUDES LABS, RESUBMIT AS AN ADJUSTMENT**	**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.	**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	**454**	Procedure code for services rendered.
390	**HOSPITAL VISITS AND CONSULTS NOT ALLOWED SAME DOB, SAME PROVIDER SPEICALTY**	**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.	**M22**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.

391	**FETAL MONITORING DENIED, REIMUBRSEMENT HAS BEEN MADE TO HOSPITAL**	**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.
392	**EVALUATION NOT ALLOWED SAME DAY AS DIAGNOSTIC ASSESSMENT DETOX INITIAL EVALUATION HOSP. ADMISSION WAIS BENDER**	**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.	**M22**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
393	**DACYACYSTOGRAPHY INCLUDES INJECTION OF CONTRAST MEDIUM. RESUBMIT AS AN ADJUSTMENT**	**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.
394	**NOT IN ACCORDANCE WITH MEDICAL POLICY GUIDELINES**	**B5**	Coverage-program guidelines were not met or were exceeded.		**No Mapping Required**	**258**	Days-units for procedure-revenue code.
395	**DELIVERY OF PLACENTA, EXTERNAL CPHALIC VERSION, OR SPECIAL MISCELLANEOUS SERVICES ARE INCLUDED IN THE FEE FOR DELIVERY**	**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.

396	**CARBON DIOXIDE DETERMINATION 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.
397	**DILATION AND CURRETTAGE INCLUDED IN BIOPSY OF CERVIX, CIRCUMFERENTIAL CONE WITH OR WITHOUT D&C. RESUBMIT AS AN ADJUSTMENT**	**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.
397	**DILATION AND CURRETTAGE INCLUDED IN BIOPSY OF CERVIX, CIRCUMFERENTIAL CONE WITH OR WITHOUT D&C. RESUBMIT AS AN ADJUSTMENT**	**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.	**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	**454**	Procedure code for services rendered.
398	**IMMUNIZATIONS COVERED ONLY IN HEALTH CHECK FOR RECIPIENTS UNDER 21**	**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		**No Mapping Required**	**91**	Entity not eligible-not approved for dates of service.

399	**OFFICE VISITS AND CVONSULTS NOT ALLOWED SAME DOS, SAME PROVIDER SPECIALTYAS**	**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.
400	**ADMISION/MEDICAL VISITS/OBSERVATION UNIT NOT ALLOWED SAME DATE OF SERVICE**	**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.
401	**MEDICAL VISITS/OBSERVATION UNIT NOT ALLOWED SAME DATE OF SERVICE**	**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.

402	**OBSERVATION UNIT/MEDICAL VISITS NOT ALLOWED SAME DATE OF SERVICE**	**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.
403	**MEDICAL VISITS/ADMISSION NOT ALLOWED SAME DAY AS INITIAL OBSERVATION**	**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.
404	**PERSONAL CARE SERVICE NOT ALLOWED SAME DAY AS HOME HEALTH AIDE SERVICES**	**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.

405	**HOME HEALTH AIDE SERVICES NOT ALLOWED SAME DAY AS PERSONAL CARE SERVICE**	**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.
406	**INITIAL HOSPITAL CARE NOT ALLOWED SAME DATE OF SERVICES AS DENTAL EXAM**	**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.
407	**MEDICAL VISITS/EPIDURAL FOLLOW UP NOT ALLOWED ON THE SAME DATE OF SERVICE**	**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.
408	**FOLLOW UP FOR BOTH EYES HAS BEEN BILLED, Y5575 NOT ALLOWED**	**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.

409	**EPIDURAL FOLLOW-UP/MEDICAL VISITS NOT ALLOWED ON THE SAME DATE OF SERVICE**	**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.
410	**PANEL PARTIALLY PAID ON PREVIOUS CLAIM DETAIL**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
411	**PANEL PARTIALLY PAID ON PREVIOUS CLAIM DETAIL**	**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.
412	**Blood gases 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.

413	**BLOOD GASES 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.
414	**ROUTINE/CONTINUOUS HOME CARE INPATIENT RESPITE CARE/GENERAL INPATIENT CARE NOT ALLOWED SAME DATE OF SERVICE**	**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.
415	**CONTINUOUS HOME CARE/INPATRIENT RESPITE CARE/GENERAL INPATIENT CARE NOT ALLOWED SAME DATE OF SERVICE**	**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.
416	**ROUTINE HOME CARE/GENERAL RESPITE CARE/GENERAL INPATIENT CARE CANNOT BE BILLED ON SAME DATE OF SERVICE AS CONTINUOUS HOME CARE**	**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.

417	**ROUTINE HOME CARE/INPATIENT RESPITE CARE/GENEAL INPATIENT CARE NOT ALLOWED SAME DATE OF SERVICE AS CONTINUOUS HOME CARE**	**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.	**M22**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
418	**General inpatient care not allowed same day as routine home care-continuous home care- inpatient respite care-hospice- LTC.**	**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.	**M22**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
419	**ROUTINE HOME CARE NOT ALLOWED SAME DAY AS ROUTINE HOME CARE/CONTINUOUS HOME CARE/INPATIENT RESPITE CARE/HOSPICE LTC**	**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.

420	**ROUTINE HOME CARE/CONTINOUS HOME CARE/INPATIENT RESPITE CARE/HOSPICE-LTC NOT ALLOWED SAME DAY AS GENERAL INP. CARE**	**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.
421	**INPATIENT RESPITE CARE NOT ALLOWED SAME DAY AS ROUTINE HOME CARE/CONTINOUS HOME CARE /GENERAL INPATIENT CARE/HOSPICE-LTC**	**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.
	GENERAL CARE ALLOWED PER						

424	**DATE OF SERVICE ON CLAIM AND CONSENT FORM DIFFER. CORRECT AND RESUBMIT AS ADJUSTMENT WITH CLAIM AND CONSENT ATTACHED**	**125**	Submission-billing error(s)	**N3**	Missing consent form	**187**	Date(s) of service.
424	**DATE OF SERVICE ON CLAIM AND CONSENT FORM DIFFER. CORRECT AND RESUBMIT AS ADJUSTMENT WITH CLAIM AND CONSENT ATTACHED**	**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.
425	**ILLEGIBLE CONSENT FORM RECEIVED, RESUBMIT LEGIBLE CONSENT FORM**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**123**	Additional information requested from entity.
425	**ILLEGIBLE CONSENT FORM RECEIVED, RESUBMIT LEGIBLE CONSENT FORM**	**16**	Claim-service lacks information which is needed for adjudication	**N205**	Information provided was illegible.	**123**	Additional information requested from entity.
427	**PHYSICIANS INITIALS ARE NOT ACCEPTABLE ON THE STERILIZATION CONSENT FORM AND-OR THE PHYSICIANS FULL SIGNATURE MUST BE DATED ON THE DATE OF SURGERY OR AFTER**	**16**	Claim-service lacks information which is needed for adjudication	**MA70**	Missing-incomplete-invalid provider representative signature	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
427	**PHYSICIANS INITIALS ARE NOT ACCEPTABLE ON THE STERILIZATION CONSENT FORM AND-OR THE PHYSICIANS FULL SIGNATURE MUST BE DATED ON THE DATE OF SURGERY OR AFTER**	**16**	Claim-service lacks information which is needed for adjudication	**MA71**	Missing-incomplete-invalid provider representative signature date.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

427	**PHYSICIANS INITIALS ARE NOT ACCEPTABLE ON THE STERILIZATION CONSENT FORM AND-OR THE PHYSICIANS FULL SIGNATURE MUST BE DATED ON THE DATE OF SURGERY OR AFTER**	**16**	Claim-service lacks information which is needed for adjudication	**MA70**	Missing-incomplete-invalid provider representative signature	**466**	Entities original signature.
427	**PHYSICIANS INITIALS ARE NOT ACCEPTABLE ON THE STERILIZATION CONSENT FORM AND-OR THE PHYSICIANS FULL SIGNATURE MUST BE DATED ON THE DATE OF SURGERY OR AFTER**	**16**	Claim-service lacks information which is needed for adjudication	**MA71**	Missing-incomplete-invalid provider representative signature date.	**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.
427	**PHYSICIANS INITIALS ARE NOT ACCEPTABLE ON THE STERILIZATION CONSENT FORM AND-OR THE PHYSICIANS FULL SIGNATURE MUST BE DATED ON THE DATE OF SURGERY OR AFTER**	**16**	Claim-service lacks information which is needed for adjudication	**MA70**	Missing-incomplete-invalid provider representative signature	**467**	Entity signature date.
427	**PHYSICIANS INITIALS ARE NOT ACCEPTABLE ON THE STERILIZATION CONSENT FORM AND-OR THE PHYSICIANS FULL SIGNATURE MUST BE DATED ON THE DATE OF SURGERY OR AFTER**	**16**	Claim-service lacks information which is needed for adjudication	**MA71**	Missing-incomplete-invalid provider representative signature date.	**467**	Entity signature date.
428	**ADMISSION TYPE 2-URGENT NOT ACCEPTABLE FOR INPATIENT PSYCHIATRIC ADMISSION.**	**125**	Submission-billing error(s)	**MA41**	Missing-incomplete-invalid admission type.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

429	**SCREENING NOT ALLOWED SAME DAY AS DIAGNOSTIC ASSESSMENT, DETOX INITIAL EVALUATION, HOSP ADMISSION, WAIS BENDER**	**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.
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.
431	**OUTPATIENT TREATMENT NOT ALLOWED SAME DAY AS THERAPY, CRISIS MANAGEMENT, MEDICATION ADMINISTRATION OR HOSPITAL VISITS**	**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.	**M22**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
432	**HEALTH CHECK SCREENING NOT ALLOWED ON THE SAME DAY AS VISION AND HEARING SCREENINGS**	**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.

433	**VISION/HEARING SCREEN NOT ALLOWED ON THE SAME DAY AS HEALTH-CHECK SCREENING**	**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.
434	**Components of code 52285 have been billed and paid separately-file adjustment if necessary.**	**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.
435	**Combine codes-charges and bill to the all inclusive code 52285.**	**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.
436	**SAIOP is not allowed same date of service as partial hospitalization and-or day treatment**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service
437	**90742 and related vaccines (hibg, rig, tig, vzig) are not allowed on the same date of service.**	**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.

438	**THE DATE ASSOCIATED WITH OCCURRENCE CODE INDICATES THIS CLAIM MUST BE SUBMITTED TO PRIMARY PAYER**	**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.
438	**THE DATE ASSOCIATED WITH OCCURRENCE CODE INDICATES THIS CLAIM MUST BE SUBMITTED TO PRIMARY PAYER**	**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.	**720**	NUBC Occurrence Code Date(s)
439	**INFORMATION ON VALUE CODE-VALUE AMOUNT IS MISSING OR INCOMPLETE. REBILL WITH COMPLETE VALUE CODE DATE. REFER TO UB MANUAL**	**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.
439	**INFORMATION ON VALUE CODE-VALUE AMOUNT IS MISSING OR INCOMPLETE. REBILL WITH COMPLETE VALUE CODE DATE. REFER TO UB MANUAL**	**125**	Submission-billing error(s)	**M49**	Missing-incomplete-invalid value code(s) or amount(s).	**123**	Additional information requested from entity.
439	**INFORMATION ON VALUE CODE-VALUE AMOUNT IS MISSING OR INCOMPLETE. REBILL WITH COMPLETE VALUE CODE DATE. REFER TO UB MANUAL**	**125**	Submission-billing error(s)	**M49**	Missing-incomplete-invalid value code(s) or amount(s).	**726**	NUBC Value Code Amount(s)
440	**Suspect dupe-exact service dated 4 digit procedure, prof. 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.
441	**Suspect dupe-exact service date, billed amount inst 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.

442	**Out patient charges are included in inpatient reimbursement.**	**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.
443	**Inpatient claim paid, previously paid outpatient claim will be recouped.**	**16**	Claim-service lacks information which is needed for adjudication	**M22**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
444	**Medical screening exam fee denied due to inpatient claim paid in history for the same date of service.**	**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.	**M22**	Not paid separately when the patient is an inpatient. M86 - Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
445	**HIT SERVICE NOT ALLOWED SAME DAY AS INPATIENT SERVICE**	**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.	**M22**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
446	**Suspect duplicate- overlapping DOS-same proc. code-prof.**	**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.
447	**Inpatient claim paid; previously paid medical screening exam fee will be recouped.**	**169**	Alternate benefit has been provided	**M22**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.

448	**Inpatient services paid; previously paid HIT services will be recouped.**	**169**	Alternate benefit has been provided	**M22**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
449	**HIV Case Management denied due to inpatient claim paid with same date of service. Case management fee is included in the hospital inpatient per diem.**	**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.	**M22**	Not paid separately when the patient is an inpatient.	**454**	Procedure code for services rendered.
450	**Less severe dupe prof 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.
451	**Less severe dupe same hour prof 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.
452	**Nursing home claim denied. Patient was inpatient for some of these date of service. Rebill for covered days only. Correct and resubmit as a new claim.**	**152**	Payer deems the information submitted does not support this length of service. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M22**	Not paid separately when the patient is an inpatient.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
452	**Nursing home claim denied. Patient was inpatient for some of these date of service. Rebill for covered days only. Correct and resubmit as a new claim.**	**152**	Payer deems the information submitted does not support this length of service. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M22**	Not paid separately when the patient is an inpatient.	**56**	Awaiting eligibility determination.
453	**Less severe dupe same provider 4 digit procedure, same service date, prof 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.

454	**DEBRIDEMENT ONLY ALLOWED WHEN BILLED ON THE SAME DAY AS SURGICAL CLEANING OF SKIN**	**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 Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
454	**DEBRIDEMENT ONLY ALLOWED WHEN BILLED ON THE SAME DAY AS SURGICAL CLEANING OF SKIN**	**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.	**454**	Procedure code for services rendered.
455	**Biopsy of skin only allowed when billed on the same day as biopsy of skin lesion.**	**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.	**454**	Procedure code for services rendered.
456	**Each additional ten lesions only allowed on same date of service as removal of skin tags up to and including 15 lesions.**	**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.	**454**	Procedure code for services rendered.
457	**AVULSIONS OF NAIL PLATE ONLY ALLOWED WHEN BILLED ON THE SAME DAY AS REMOVAL OF NAIL**	**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.	**454**	Procedure code for services rendered.

457	**AVULSIONS OF NAIL PLATE ONLY ALLOWED WHEN BILLED ON THE SAME DAY AS REMOVAL OF NAIL**	**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.	**454**	Procedure code for services rendered.
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.
460	**Exact dupe prof 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.
461	**Exact dupe same hour prof 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.
462	**Inpatient claim must include out patient charges incurred within 24 hrs of admission. Outpatient charges billed separately have been denied or recouped. Correct and resubmit inpatient claim.**	**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.	**M22**	Not paid separately when the patient is an inpatient.	**454**	Procedure code for services rendered.
463	**TATTOOING ONLY ALLOWED WHEN BILLED ON THE SAME DAY AS CORRECT SKIN COLOR DEFECTS**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.

463	**TATTOOING ONLY ALLOWED WHEN BILLED ON THE SAME DAY AS CORRECT SKIN COLOR DEFECTS**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
464	**EACH ADDITIONAL 100 SQ CM ONLY ALLOWED WHEN BILLED ON THE SAME DAY AS SPLIT GRAFT 100 SQ CM OR LESS**	**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.	**454**	Procedure code for services rendered.
464	**EACH ADDITIONAL 100 SQ CM ONLY ALLOWED WHEN BILLED ON THE SAME DAY AS SPLIT GRAFT 100 SQ CM OR LESS**	**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.	**454**	Procedure code for services rendered.
465	**Outpt charges within 24 hrs of admit not paid separately. Add charges to inpt claim & resubmit replacement claim. If mult encounter, bill others not 24 hrs of admit, separately.**	**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.	**M2**	Not paid separately when the patient is an inpatient.	**454**	Procedure code for services rendered.
466	**FULL THICKNESS GRAFT, EACH ADD'L 20 SQ CM MUST BILL WITH 20 SQ CM OR LESS**	**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.	**454**	Procedure code for services rendered.

466	**FULL THICKNESS GRAFT, EACH ADD'L 20 SQ CM MUST BILL WITH 20 SQ CM OR LESS**	**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.	**454**	Procedure code for services rendered.
467	**Suspect duplicate, overlapping dates 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.
468	**Each additional four lesions or less only allowed when billed on the same day as abrasions; single lesion.**	**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.	**454**	Procedure code for services rendered.
468	**Each additional four lesions or less only allowed when billed on the same day as abrasions; single lesion.**	**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.	**454**	Procedure code for services rendered.
469	**Suspect duplicate, overlapping dates of service inst.**	**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.
470	**SUSPECT DUPLICATE, OVERLAPPING DATES OF SERVICE INST.**	**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.
471	**Part B charges included in per diem.**	**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.

472	**Suspect duplicate, overlapping dates of service inst.**	**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.
473	**NURSING HOME DAYS DENIED OR RECOUPED TO PAY INPATIENT HOSPITAL DAYS**	**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.	**M2**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
473	**NURSING HOME DAYS DENIED OR RECOUPED TO PAY INPATIENT HOSPITAL DAYS**	**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.
474	**Suspect dupe-overlap service date, prof 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.
475	**Suspect dupe-exact service date, prof 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.
476	**SUSPECT DUPE PROF 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.
477	**SUSPECT DUPE PROF 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.

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.
479	**SUSPECT DUPE PROF 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.
480	**Less severe dupe prof 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.
481	**Less severe dupe-outpatient hour. system 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.
482	**LESS SEVERE DUPE INST 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.
483	**LESS SEVERE DUPE INST 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.
484	**LESS SEVERE DUPE INST 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.
485	**LESS SEVERE DUPE INST 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.
486	**LESS SEVERE DUPE INST 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.
487	**Less severe dupe-3 digit procedure, prof 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.
489	**Less severe dupe prof 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.
490	**DUPLICATE DENIED**	**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.
491	**Exact dupe-same provider-DOS-prescription number.**	**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.
492	**Exact dupe-overlap service date, inst 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.
493	**Exact dupe inst 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.
494	**Exact dupe prof 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.
495	**EACH ADDITIONAL CYST ONLY ALLOWED WHEN BILLED ON THE SAME DAY AS PUNCTURE ASPIRATION OF CYST OF BREAST**	**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.	**454**	Procedure code for services rendered.
495	**EACH ADDITIONAL CYST ONLY ALLOWED WHEN BILLED ON THE SAME DAY AS PUNCTURE ASPIRATION OF CYST OF BREAST**	**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.	**454**	Procedure code for services rendered.

496	**Exact dupe x-over prof 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.
497	**Exact dupe-3digit procedure, prof 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.
499	**Exact dupe prof 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.
500	**Routine follow up care included in surgical fee.**	**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.
501	**Admission history and physical or pre-operative care paid prior to surgery, resubmit as an adjustment.**	**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.
502	**CAP LIMITATION HAS BEEN 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.
502	**CAP LIMITATION HAS BEEN 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.
502	**CAP LIMITATION HAS BEEN EXCEEDED**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
502	**CAP LIMITATION HAS BEEN 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	**483**	Maximum coverage amount met or exceeded for benefit period.

503	**ALLOW 1 AUSTRAILIAN ANTIGEN LAB-MO FOR CRD RECIPIENTS**	**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.
503	**ALLOW 1 AUSTRAILIAN ANTIGEN LAB-MO FOR CRD RECIPIENTS**	**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.
504	**Allow 1 bone survey-year for crd recipients.**	**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.
505	**Unacceptable consent form copy. Resubmit consent form copy with all field showing.**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**123**	Additional information requested from entity.
506	**Surgery fee includes admission hist- physical and pre-op 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.
507	**Procedure code 95957 allowed only in conjunction with codes 95816,95819, or 95954. EEG must be billed prior to payment for code 95957.**	**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.	**454**	Procedure code for services rendered.
507	**Procedure code 95957 allowed only in conjunction with codes 95816,95819, or 95954. EEG must be billed prior to payment for code 95957.**	**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.	**454**	Procedure code for services rendered.
508	**BITEWING X-RAYS ALLOWED ONCE WITHIN 12 CALENDAR MONTHS**	**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.

508	**BITEWING X-RAYS ALLOWED ONCE WITHIN 12 CALENDAR MONTHS**	**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.
508	**BITEWING X-RAYS ALLOWED ONCE WITHIN 12 CALENDAR MONTHS**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M90**	Not covered more than once in a 12 month period.	**483**	Maximum coverage amount met or exceeded for benefit period.
508	**BITEWING X-RAYS ALLOWED ONCE WITHIN 12 CALENDAR MONTHS**	**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.
509	**ALLOW 2 PSYCHIATRIC OUTPATIENT VISITS WITHOUT PRIOR APPROVAL**	**197**	Precertification-authorization-notification absent.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**48**	Referral-authorization.
509	**ALLOW 2 PSYCHIATRIC OUTPATIENT VISITS WITHOUT PRIOR APPROVAL**	**197**	Precertification-authorization-notification absent.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**259**	Frequency of service.
510	**Allow 1 visit-day for migrant-rural-free-standing clinics.**	**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.
511	**Services covered by Medicare, bill Medicare 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.
512	**CAP LIMITATION HAS BEEN 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.
512	**CAP LIMITATION HAS BEEN 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.
512	**CAP LIMITATION HAS BEEN EXCEEDED**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.

512	**CAP LIMITATION HAS BEEN 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	**483**	Maximum coverage amount met or exceeded for benefit period.
513	**INPATIENT RESPITE CARE, RC655 NOT ALLOWED MORE THAN 5 CONSECUTIVE DAYS. SPLIT AND REBILL ALL SUBSEQUENT DAYS OF HOSPITAL STAY AS RC651 ROUTINE HOME CARE**	**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.	**M53**	Missing-incomplete-invalid days or units of service.	**258**	Days-units for procedure-revenue code.
513	**INPATIENT RESPITE CARE, RC655 NOT ALLOWED MORE THAN 5 CONSECUTIVE DAYS. SPLIT AND REBILL ALL SUBSEQUENT DAYS OF HOSPITAL STAY AS RC651 ROUTINE HOME CARE**	**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.	**N61**	Rebill services on separate claims.	**258**	Days-units for procedure-revenue code.
513	**INPATIENT RESPITE CARE, RC655 NOT ALLOWED MORE THAN 5 CONSECUTIVE DAYS. SPLIT AND REBILL ALL SUBSEQUENT DAYS OF HOSPITAL STAY AS RC651 ROUTINE HOME CARE**	**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.	**N63**	Rebill services on separate claim lines.	**258**	Days-units for procedure-revenue code.
514	**CAP LIMITATION HAS BEEN 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.

514	**CAP LIMITATION HAS BEEN 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.
514	**CAP LIMITATION HAS BEEN EXCEEDED**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
514	**CAP LIMITATION HAS BEEN 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	**483**	Maximum coverage amount met or exceeded for benefit period.
515	**Service included in Health Check package.**	**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.
516	**Not in accordance with rehab 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
					between this service-procedure-		

520	**LAD TEST ALLOWED ONCE EVERY 3 MONTHS FOR CRD**	**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.
520	**LAD TEST ALLOWED ONCE EVERY 3 MONTHS FOR CRD**	**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.
521	**SUPPLY CODE DENIED. ADDITIONAL PAYMENT NOT ALLOWED PAYMENT NOT ALLOWED UNLESS FACILITY-BASED PROCEDURE HAS BEEN PERFORMED IN PHYSCIAN OFFICE**	**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 services billed or the date of service billed.	**258**	Days-units for procedure-revenue code.
521	**SUPPLY CODE DENIED. ADDITIONAL PAYMENT NOT ALLOWED PAYMENT NOT ALLOWED UNLESS FACILITY-BASED PROCEDURE HAS BEEN PERFORMED IN PHYSCIAN OFFICE**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M77**	Incomplete-invalid place of service(s).	**258**	Days-units for procedure-revenue code.
522	**Individual sealant included in Quadrant previously billed.**	**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.
523	**Code multiple lab tests on the same day to the 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.

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.
525	**Exceeds legislative limits for provider visits for fiscal year.**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**259**	Frequency of service.
526	**Billed procedure only allowed on same day as Y2038, Y2027,Y2039or Y2040.**	**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.	**454**	Procedure code for services rendered.

526	**Billed procedure only allowed on same day as Y2038, Y2027,Y2039or Y2040.**	**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.	**454**	Procedure code for services rendered.
527	**Laboratory services included in hospital reimbursement.**	**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.
528	**COMBINE CHARGES AND REBILL USING MAJOR SURGERY CODE. INDICATE TOTAL TIME UNITS IN COLUMN G. FILE ADJUSTMENT OF PREVIOUSLY PAID CLAIM IF NECESSARY**	**A1**	Claim-Service denied	**MA51**	Missing-incomplete-invalid procedure code(s).	**258**	Days-units for procedure-revenue code.
528	**COMBINE CHARGES AND REBILL USING MAJOR SURGERY CODE. INDICATE TOTAL TIME UNITS IN COLUMN G. FILE ADJUSTMENT OF PREVIOUSLY PAID CLAIM IF NECESSARY**	**A1**	Claim-Service denied	**N203**	Missing-incomplete-invalid anesthesia time-units	**258**	Days-units for procedure-revenue code.
528	**COMBINE CHARGES AND REBILL USING MAJOR SURGERY CODE. INDICATE TOTAL TIME UNITS IN COLUMN G. FILE ADJUSTMENT OF PREVIOUSLY PAID CLAIM IF NECESSARY**	**A1**	Claim-Service denied	**MA51**	Missing-incomplete-invalid procedure code(s).	**454**	Procedure code for services rendered.

528	**COMBINE CHARGES AND REBILL USING MAJOR SURGERY CODE. INDICATE TOTAL TIME UNITS IN COLUMN G. FILE ADJUSTMENT OF PREVIOUSLY PAID CLAIM IF NECESSARY**	**A1**	Claim-Service denied	**N203**	Missing-incomplete-invalid anesthesia time-units	**454**	Procedure code for services rendered.
528	**COMBINE CHARGES AND REBILL USING MAJOR SURGERY CODE. INDICATE TOTAL TIME UNITS IN COLUMN G. FILE ADJUSTMENT OF PREVIOUSLY PAID CLAIM IF NECESSARY**	**A1**	Claim-Service denied	**MA51**	Missing-incomplete-invalid procedure code(s).	**523**	Anesthesia Unit Count
528	**COMBINE CHARGES AND REBILL USING MAJOR SURGERY CODE. INDICATE TOTAL TIME UNITS IN COLUMN G. FILE ADJUSTMENT OF PREVIOUSLY PAID CLAIM IF NECESSARY**	**A1**	Claim-Service denied	**N203**	Missing-incomplete-invalid anesthesia time-units	**523**	Anesthesia Unit Count
529	**Rebill assistant surgeon on separate claim form.**	**125**	Submission-billing error(s)	**N93**	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
530	**Services included in initial dialysis training fee.**	**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.

531	**Service included in monthly professional dialysis fee.**	**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.
532	**ONLY ONE EKG ALLOWED IN 3 MONTHS FOR DIALYSIS PATIENTS**	**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.
532	**ONLY ONE EKG ALLOWED IN 3 MONTHS FOR DIALYSIS PATIENTS**	**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.
533	**ONLY ONE NERVE VELOCITY TEST ALLOWED IN 3MTHS FOR DIALYSIS**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within	**259**	Frequency of service.
					between this service-procedure-		

537	**PROCEDURE CODE OR PROCEDURE-MODIFIER CODE COMBINATION IS NOT COVERED FOR THE 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.	**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.
537	**PROCEDURE CODE OR PROCEDURE-MODIFIER CODE COMBINATION IS NOT COVERED FOR THE 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).	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
537	**PROCEDURE CODE OR PROCEDURE-MODIFIER CODE COMBINATION IS NOT COVERED FOR THE 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.	**N56**	Procedure code billed is not correct-valid for the service billed or the date of service billed.	**457**	Non-Covered Day(s).
537	**PROCEDURE CODE OR PROCEDURE-MODIFIER CODE COMBINATION IS NOT COVERED FOR THE 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).	**457**	Non-Covered Day(s).
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.
539	**EXCEEDS LIMIT FOR SCREENING MAMMOGRAM: AGE 35-39 ALLOW ONE; AGE 40 AND OVER ALLOW ANNUAL EXAM**	**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.
539	**EXCEEDS LIMIT FOR SCREENING MAMMOGRAM: AGE 35-39 ALLOW ONE; AGE 40 AND OVER ALLOW ANNUAL EXAM**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N130**	Alert- Consult plan benefit documents for information about restrictions for this service.	**259**	Frequency of service.

539	**EXCEEDS LIMIT FOR SCREENING MAMMOGRAM: AGE 35-39 ALLOW ONE; AGE 40 AND OVER ALLOW ANNUAL EXAM**	**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.
540	**Initial dialysis training includes fee for other 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.
541	**Monthly professional dialysis includes fee for other 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.
542	**Routine follow up is included in surgical fee.**	**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.

543	**Tympanometry and Health Check screening are not allowed on the 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.	**N203**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
544	**Chemotherapy administration denied, ov or consult included in administration fee previously paid to the same provider for this date of 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.
545	**PDN services is non-covered when recipient is receiving inpatient services.**	**96**	Non-covered charge(s). 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.	**454**	Procedure code for services rendered.
546	**Chemo admin code includes surgical procedure previously paid to same provider for same DOS. Refund or request recoupment of paid surgery code for reconsideration of chemo admin 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.
547	**Only one initial consult allowed in a 15 day 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.

548	**PROC CODE BILLED NOT ALLOWED IN CLIENT'S CAP PGM. REBILL USING THE CORRECT PROC CODE OR CONFRIM CLIENT'S CAP STATUS WITH CAP MGR. FOR FURTHER RESOLUTION CALL HP NPI HELPDESK**	**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.	**N30**	Patient ineligible for this service.	**258**	Days-units for procedure-revenue code.
548	**PROC CODE BILLED NOT ALLOWED IN CLIENT'S CAP PGM. REBILL USING THE CORRECT PROC CODE OR CONFRIM CLIENT'S CAP STATUS WITH CAP MGR. FOR FURTHER RESOLUTION CALL HP NPI HELPDESK**	**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.	**N52**	Patient not enrolled in the billing providers managed care plan on the date of service.	**258**	Days-units for procedure-revenue code.
					between this service-procedure-		

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.
551	**ESRD related services allowed once per month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
552	**THERAPEUTIC RADIOLOGY PORT FILMS ALLOWED ONCE 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.
552	**THERAPEUTIC RADIOLOGY PORT FILMS ALLOWED ONCE 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
553	**RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION OF TIME**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart.	**263**	Length of time for services rendered
553	**RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION OF TIME**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart.	**294**	Supporting documentation
554	**Chronic disease monitoring and components(Y2006, Y2007 and Y2024) not allowed on the same day of service.**	**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.

555	**Daily and monthly ESRD related services not allowed within the same calendar month.**	**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.
556	**PRIMARY DIAGNOSIS CODE MUST BE FURTHER SUBDIVIDED. THE CODE MUST HAVE FOUR OR FIVE DIGITS**	**146**	Diagnosis was invalid for the date(s) of service reported.	**MA63**	Missing-incomplete-invalid principal diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
556	**PRIMARY DIAGNOSIS CODE MUST BE FURTHER SUBDIVIDED. THE CODE MUST HAVE FOUR OR FIVE DIGITS**	**146**	Diagnosis was invalid for the date(s) of service reported.	**MA63**	Missing-incomplete-invalid principal diagnosis.	**255**	Diagnosis code.
557	**SECONDARY DIAGNOSIS CODE MUST BE FURTHER SUBDIVIDED. (THE CODE MUST HAVE FOUR OR FIVE DIGITS)**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
557	**SECONDARY DIAGNOSIS CODE MUST BE FURTHER SUBDIVIDED. (THE CODE MUST HAVE FOUR OR FIVE DIGITS)**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
558	**OTHER DIAGNOSIS CODE 3 MUST BE FURTHER SUBDIVIDED. (THE CODE MUST HAVE FOUR OR FIVE DIGITS)**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

558	**OTHER DIAGNOSIS CODE 3 MUST BE FURTHER SUBDIVIDED. (THE CODE MUST HAVE FOUR OR FIVE DIGITS)**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
559	**OTHER DIAGNOSIS CODE 4 MUST BE FURTHER SUBDIVIDED. (THE CODE MUST HAVE FOUR OR FIVE DIGITS)**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
559	**OTHER DIAGNOSIS CODE 4 MUST BE FURTHER SUBDIVIDED. (THE CODE MUST HAVE FOUR OR FIVE DIGITS)**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
560	**OTHER DIAGNOSIS CODE 5 MUST BE FURTHER SUBDIVIDED**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
560	**OTHER DIAGNOSIS CODE 5 MUST BE FURTHER SUBDIVIDED**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
561	**ACELLULAR DTP VACCINE ALLOWED ONCE PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	259 - Frequency of service.
561	**ACELLULAR DTP VACCINE ALLOWED ONCE PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
562	**Service is included in the chemotherapy administration code previously paid to the same provider for this DOS.**	**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.

563	**AUDIOLOGY ASSESSMENT LIMITED TO 2 HOURS (8 UNITS) 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.
563	**AUDIOLOGY ASSESSMENT LIMITED TO 2 HOURS (8 UNITS) PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
563	**AUDIOLOGY ASSESSMENT LIMITED TO 2 HOURS (8 UNITS) 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
563	**AUDIOLOGY ASSESSMENT LIMITED TO 2 HOURS (8 UNITS) PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount
564	**SPEECH-LANGUAGE ASSESSMENT LIMITED TO 2 HOURS (8 UNITS) 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.
564	**SPEECH-LANGUAGE ASSESSMENT LIMITED TO 2 HOURS (8 UNITS) PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
564	**SPEECH-LANGUAGE ASSESSMENT LIMITED TO 2 HOURS (8 UNITS) 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
564	**SPEECH-LANGUAGE ASSESSMENT LIMITED TO 2 HOURS (8 UNITS) PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount
565	**ASSESSMENTS LIMITED TO TWO HOURS (8 UNITS) 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.
565	**ASSESSMENTS LIMITED TO TWO HOURS (8 UNITS) PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
565	**ASSESSMENTS LIMITED TO TWO HOURS (8 UNITS) 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

565	**ASSESSMENTS LIMITED TO TWO HOURS (8 UNITS) PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount
566	**PHYSICAL THERAPY ASSESSMENT LIMITED TO 2 HOURS (8 UNITS0 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.
566	**PHYSICAL THERAPY ASSESSMENT LIMITED TO 2 HOURS (8 UNITS0 PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
566	**PHYSICAL THERAPY ASSESSMENT LIMITED TO 2 HOURS (8 UNITS0 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
566	**PHYSICAL THERAPY ASSESSMENT LIMITED TO 2 HOURS (8 UNITS0 PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount
567	**PSYCHOLOGY ASSESSMENT LIMITED TO 2 HOURS (8 UNITS) 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.
567	**PSYCHOLOGY ASSESSMENT LIMITED TO 2 HOURS (8 UNITS) PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
567	**PSYCHOLOGY ASSESSMENT LIMITED TO 2 HOURS (8 UNITS) 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
567	**PSYCHOLOGY ASSESSMENT LIMITED TO 2 HOURS (8 UNITS) PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount
568	**DEPO-PROVERA 150 MG. FOR CONTRACEPTIVE USE LIMITED TO ONE PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
568	**DEPO-PROVERA 150 MG. FOR CONTRACEPTIVE USE LIMITED TO ONE PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount

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**	**197**	Precertification-authorization-	**N56**	Procedure code billed is not	**453**	Procedure code modifier(s) for
					between this service-procedure-		

570	**PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY LIMIT TO FOUR PER DAY**	**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	**612**	Per Day Limit Amount
571	**LIMIT PERCUTANEOUS TRANSLUMINAL ATHERECTOMY TO FOUR 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.
571	**LIMIT PERCUTANEOUS TRANSLUMINAL ATHERECTOMY TO FOUR PER DAY**	**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.
571	**LIMIT PERCUTANEOUS TRANSLUMINAL ATHERECTOMY TO FOUR PER**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within	**612**	Per Day Limit Amount
					between this service-procedure-		

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).
576	**W9922 can only be billed for Carolina access recipients.**	**150**	Payer deems the information submitted does not support this level of service	**MA66**	Missing-incomplete-invalid principal procedure code.	**97**	Patient eligibility not found with entity.

577	**PCP'S CANNOT BILL W9922 FOR THEIR ENROLLED RECIPIENTS**	**150**	Payer deems the information submitted does not support this level of service	**MA66**	Missing-incomplete-invalid principal procedure code.	**97**	Patient eligibility not found with entity.
577	**PCP'S CANNOT BILL W9922 FOR THEIR ENROLLED RECIPIENTS**	**150**	Payer deems the information submitted does not support this level of service	**N188**	The approved level of care does not match the procedure code submitted	**97**	Patient eligibility not found with entity.
578	**NON ER SERVICES BILLED FOR CA RECIPIENT WITH INVALID ADMIT HOUR. REBILL WITH ADMIT HOUR**	**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.
578	**NON ER SERVICES BILLED FOR CA RECIPIENT WITH INVALID ADMIT HOUR. REBILL WITH ADMIT HOUR**	**125**	Submission-billing error(s)	**N46**	Missing-incomplete-invalid admission hour.	**230**	Hospital admission hour.
578	**NON ER SERVICES BILLED FOR CA RECIPIENT WITH INVALID ADMIT HOUR. REBILL WITH ADMIT HOUR**	**125**	Submission-billing error(s)	**N46**	Missing-incomplete-invalid admission hour.	**471**	Were services related to an emergency?
579	**DIAG NOT TRUE EMERGENCY. SERVICE RENDERED 5PM TO 8AM MONDAY THRU FRIDAY. RESUBMIT NEW CLAIM FOR MED SCREENING EXAM FEE (W9922) TO HP OR SUBMIT CLAIM TO CAROLINA ACCESS FOR RETROSPECTIVE REVIEW**	**125**	Submission-billing error(s)	**MA63**	Missing-incomplete-invalid principal diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

579	**DIAG NOT TRUE EMERGENCY. SERVICE RENDERED 5PM TO 8AM MONDAY THRU FRIDAY. RESUBMIT NEW CLAIM FOR MED SCREENING EXAM FEE (W9922) TO HP OR SUBMIT CLAIM TO CAROLINA ACCESS FOR RETROSPECTIVE REVIEW**	**125**	Submission-billing error(s)	**MA63**	Missing-incomplete-invalid principal diagnosis.	**488**	Diagnosis code(s) for the services rendered
580	**DIAGNOSIS NOT TRUE EMERGENCY. SERVICE RENDERED 5PM TO 8AM MONDAY THRU FRIDAY OR 24 HRS SAT-SUN. SERVICE MAY BE AUTHORIZED BY PCP OR BILL MEDICAL SCREENING EXAM FEE (W9922)**	**125**	Submission-billing error(s)	**MA63**	Missing-incomplete-invalid principal diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
580	**DIAGNOSIS NOT TRUE EMERGENCY. SERVICE RENDERED 5PM TO 8AM MONDAY THRU FRIDAY OR 24 HRS SAT-SUN. SERVICE MAY BE AUTHORIZED BY PCP OR BILL MEDICAL SCREENING EXAM FEE (W9922)**	**125**	Submission-billing error(s)	**MA63**	Missing-incomplete-invalid principal diagnosis.	**488**	Diagnosis code(s) for the services rendered
581	**INVALID EMERGENCY ROOM AUTHORIZATION FOR CA RECIPIENT. REBILL WITH CORRECT AUTHORIZATION OR FOR ASSESSMENT FEE W9922**	**197**	Precertification-authorization-notification absent.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**252**	Authorization-certification number.

582	**ER SERVICES PAID IN HISTORY, MEDICAL SCREENING EXAM FEE DENIED. REFILE CLAIM AS AN ADJUSTMENT AND ATTACH ER MEDICAL RECORDS**	**16**	Claim-service lacks information which is needed for adjudication	**M86**	Service denied because payment already made for similar procedure within set time frame.	**294**	Supporting documentation.
582	**ER SERVICES PAID IN HISTORY, MEDICAL SCREENING EXAM FEE DENIED. REFILE CLAIM AS AN ADJUSTMENT AND ATTACH ER MEDICAL RECORDS**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart.	**294**	Supporting documentation.
583	**MEDICAL SCREENING EXAM FEE PAID IN HISTORY . ER SERVICES DENIED. REFILE CLAIM AS AN ADJUSTMENT AND ATTACH ER MEDICAL RECORDS**	**16**	Claim-service lacks information which is needed for adjudication	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**294**	Supporting documentation.
583	**MEDICAL SCREENING EXAM FEE PAID IN HISTORY . ER SERVICES DENIED. REFILE CLAIM AS AN ADJUSTMENT AND ATTACH ER MEDICAL RECORDS**	**16**	Claim-service lacks information which is needed for adjudication	**N203**	Service not payable with other service rendered on the same date.	**294**	Supporting documentation.
587	**IF STERILIZATION CHARGES ARE NOT COVERED, REMOVE THE STERILIZATION DIAGNOSIS AND PROCEDURE CODES FROM THE CLAIM AND RESUBMIT AS A NEW CLAIM**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**178**	Submitted charges.

587	**IF STERILIZATION CHARGES ARE NOT COVERED, REMOVE THE STERILIZATION DIAGNOSIS AND PROCEDURE CODES FROM THE CLAIM AND RESUBMIT AS A NEW CLAIM**	**125**	Submission-billing error(s)	**N188**	The approved level of care does not match the procedure code submitted.	**178**	Submitted charges.
587	**IF STERILIZATION CHARGES ARE NOT COVERED, REMOVE THE STERILIZATION DIAGNOSIS AND PROCEDURE CODES FROM THE CLAIM AND RESUBMIT AS A NEW CLAIM**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**454**	Procedure code for services rendered.
587	**IF STERILIZATION CHARGES ARE NOT COVERED, REMOVE THE STERILIZATION DIAGNOSIS AND PROCEDURE CODES FROM THE CLAIM AND RESUBMIT AS A NEW CLAIM**	**125**	Submission-billing error(s)	**N188**	The approved level of care does not match the procedure code submitted.	**454**	Procedure code for services rendered.
587	**IF STERILIZATION CHARGES ARE NOT COVERED, REMOVE THE STERILIZATION DIAGNOSIS AND PROCEDURE CODES FROM THE CLAIM AND RESUBMIT AS A NEW CLAIM**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.

587	**IF STERILIZATION CHARGES ARE NOT COVERED, REMOVE THE STERILIZATION DIAGNOSIS AND PROCEDURE CODES FROM THE CLAIM AND RESUBMIT AS A NEW CLAIM**	**125**	Submission-billing error(s)	**N188**	The approved level of care does not match the procedure code submitted.	**488**	Diagnosis code(s) for the services rendered.
588	**Surgical procedure is not billed on this claim. Please remove the ICD-9 surgical procedure code and bill as a new claim.**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**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.	**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

591	**CLAIMS HISTORY SHOWS MEDICAID HAS PREVIOUSLY PADI FOR TONSILLECTOMIES FOR THIS RECIPIENT. RESUBMIT CORRECTED CLAIM OR FILE AS AN ADJUSTMENT WITH OPERATIVE NOTE AND PATH REPORT**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**65**	Claim-line has been paid.
591	**CLAIMS HISTORY SHOWS MEDICAID HAS PREVIOUSLY PADI FOR TONSILLECTOMIES FOR THIS RECIPIENT. RESUBMIT CORRECTED CLAIM OR FILE AS AN ADJUSTMENT WITH OPERATIVE NOTE AND PATH REPORT**	**16**	Claim-service lacks information which is needed for adjudication	**M30**	Missing pathology report.	**65**	Claim-line has been paid.
591	**CLAIMS HISTORY SHOWS MEDICAID HAS PREVIOUSLY PADI FOR TONSILLECTOMIES FOR THIS RECIPIENT. RESUBMIT CORRECTED CLAIM OR FILE AS AN ADJUSTMENT WITH OPERATIVE NOTE AND PATH REPORT**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**298**	Operative report.
591	**CLAIMS HISTORY SHOWS MEDICAID HAS PREVIOUSLY PADI FOR TONSILLECTOMIES FOR THIS RECIPIENT. RESUBMIT CORRECTED CLAIM OR FILE AS AN ADJUSTMENT WITH OPERATIVE NOTE AND PATH REPORT**	**16**	Claim-service lacks information which is needed for adjudication	**M30**	Missing pathology report.	**298**	Operative report.

591	**Claims history shows Medicaid has previously paid for tonsillectomies for this recipient. Resubmit corrected claim or file as an adjustment with operative note and path report.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**311**	Pathology notes-report.
591	**CLAIMS HISTORY SHOWS MEDICAID HAS PREVIOUSLY PADI FOR TONSILLECTOMIES FOR THIS RECIPIENT. RESUBMIT CORRECTED CLAIM OR FILE AS AN ADJUSTMENT WITH OPERATIVE NOTE AND PATH REPORT**	**16**	Claim-service lacks information which is needed for adjudication	**M30**	Missing pathology report.	**311**	Pathology notes-report.
592	**CLAIM HISTORY SHOWS MEDICAID HAS PREVIOUSLY PADI FOR ADENOIDECTOMIES FOR THIS RECIPIENT. RESUBMIT CORRECTED CLAIM OR FILE AS AN ADJUSTMENT WITH OPERATIVE NOTE AND PATH REPORT**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**65**	Claim-line has been paid
592	**CLAIM HISTORY SHOWS MEDICAID HAS PREVIOUSLY PADI FOR ADENOIDECTOMIES FOR THIS RECIPIENT. RESUBMIT CORRECTED CLAIM OR FILE AS AN ADJUSTMENT WITH OPERATIVE NOTE AND PATH REPORT**	**16**	Claim-service lacks information which is needed for adjudication	**M30**	Missing pathology report.	**65**	Claim-line has been paid

592	**CLAIM HISTORY SHOWS MEDICAID HAS PREVIOUSLY PADI FOR ADENOIDECTOMIES FOR THIS RECIPIENT. RESUBMIT CORRECTED CLAIM OR FILE AS AN ADJUSTMENT WITH OPERATIVE NOTE AND PATH REPORT**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**298**	Operative report
592	**CLAIM HISTORY SHOWS MEDICAID HAS PREVIOUSLY PADI FOR ADENOIDECTOMIES FOR THIS RECIPIENT. RESUBMIT CORRECTED CLAIM OR FILE AS AN ADJUSTMENT WITH OPERATIVE NOTE AND PATH REPORT**	**16**	Claim-service lacks information which is needed for adjudication	**M30**	Missing pathology report.	**298**	Operative report
592	**CLAIM HISTORY SHOWS MEDICAID HAS PREVIOUSLY PADI FOR ADENOIDECTOMIES FOR THIS RECIPIENT. RESUBMIT CORRECTED CLAIM OR FILE AS AN ADJUSTMENT WITH OPERATIVE NOTE AND PATH REPORT**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**311**	Pathology notes-report
592	**CLAIM HISTORY SHOWS MEDICAID HAS PREVIOUSLY PADI FOR ADENOIDECTOMIES FOR THIS RECIPIENT. RESUBMIT CORRECTED CLAIM OR FILE AS AN ADJUSTMENT WITH OPERATIVE NOTE AND PATH REPORT**	**16**	Claim-service lacks information which is needed for adjudication	**M30**	Missing pathology report.	**311**	Pathology notes-report

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.
594	**Service denied. Components of this blood panel have already been paid for the same date of 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.
595	**Service denied. This test is included in a related panel code already paid for the same date of 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.
596	**BILLED PROCEDURE LIMTED TO ONE PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

596	**BILLED PROCEDURE LIMTED TO ONE PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
597	**POSTPARTUM- NEWBORN HOME VISIT LIMITED TO ONE BILLING EVERY 154 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.
597	**POSTPARTUM- NEWBORN**	**119**	Benefit maximum for this time	**N357**	Time frame requirements between this service-procedure-	**259**	Frequency of service.

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.	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**259**	Frequency of service.
601	**ONLY FOUR QUADRANTS OF PERIODONTAL SURGERY ALLOWED PER LIFETIME**	**149**	Lifetime benefit maximum has been reached for this service-benefit category	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
601	**ONLY FOUR QUADRANTS OF PERIODONTAL SURGERY ALLOWED PER LIFETIME**	**149**	Lifetime benefit maximum has been reached for this service-benefit category	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
					between this service-procedure-		

604	**MAXIMUM DAILY UNITS EXCEEDED FOR SERVICE. CPT DESCRIPTION LIMITS CODE TO 8 UNITS PER DAY (1UNIT=1HOUR). CORRECT AND RESUBMIT AS A NEW CLAIM**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount
605	**ALLOW ONE ROUTINE DENTAL PROPHYLAXIS WITHIN 6 CALENDAR MONTHS**	**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.
605	**ALLOW ONE ROUTINE DENTAL**	**119**	Benefit maximum for this time	**N59**	**Alert-** Please refer to your	**483**	Maximum coverage amount
					between this service-procedure-		

607	**A VALID DATE IS REQUIRED WITH OCCURRENCE CODE. CORRECT AND RESUBMIT AS A NEW CLAIM**	**125**	Submission-billing error(s)	**N299**	Missing-incomplete-invalid occurrence date(s).	**720**	NUBC Occurrence Code Date(s)
608	**Recommended immunization schedule exceeded for this vaccine. Recipient has received same immunization within 300 days of claim 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.	**259**	Frequency of service.
609	**PAYER IDENTIFICATION IS REQUIRED ON NC MEDICAID CLAIMS. SEE BILLING GUIDELINES**	**125**	Submission-billing error(s)	**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.
609	**PAYER IDENTIFICATION IS REQUIRED ON NC MEDICAID CLAIMS. SEE BILLING GUIDELINES**	**125**	Submission-billing error(s)	**MA48**	Missing-incomplete-invalid name or address of responsible party or primary payer.	**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.	**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.
611	**Submit claim for payment to the Carolina alternatives agency responsible for the recipient's county of residence.**	**109**	Claim not covered by this payer-contractor. You must send the claim to the correct payer-contractor.		**No Mapping Required**	**116**	Claim submitted to incorrect payer.

612	**CRITICAL CARE, FIRST HOUR ALREADY PAID FOR THIS DATE. REBILL ADDITIONAL TIME USING CPT 99292**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**54**	Duplicate of a previously processed claim-line.
612	**CRITICAL CARE, FIRST HOUR ALREADY PAID FOR THIS DATE. REBILL ADDITIONAL TIME USING CPT 99292**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**454**	Procedure code for services rendered.
613	**OB echography allowed once per day, same provider.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
					between this service-procedure-		

616	**ONLY ONE 2 DIGIT MODIFIER ALLOWED PER PROC. CODE. REFILE CLAIM AND VERIFY IF FREE OR PURCHASED AND DOES NUMBER IN SERIES. THANK YOU FOR REPORTING VACCINE**	**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.	**453**	Procedure code modifier(s) for service(s) rendered.
617	**INSERTION OR REINSERTION OF IMPLANTABLE CONTRACEPTIVE CAPSULES(NORPLANT) IS ALLOWED ONCE PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
617	**INSERTION OR REINSERTION OF IMPLANTABLE CONTRACEPTIVE CAPSULES(NORPLANT) IS ALLOWED ONCE PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
618	**REMOVAL OF IMPLANTABLE CONTRACEPTIVE CAPSULE (NORPLANT) ALLOWED ONCE PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
618	**REMOVAL OF IMPLANTABLE CONTRACEPTIVE CAPSULE (NORPLANT) ALLOWED ONCE PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
619	**VERIFY SOURCE OF PRIOR PAYMENT. IF FILING FOR ADDITIONAL PAYMENT FROM MEDICAID, SUBMIT THROUGH ADJUSTMENT OR REPLACEMENT 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.

619	**VERIFY SOURCE OF PRIOR PAYMENT. IF FILING FOR ADDITIONAL PAYMENT FROM MEDICAID, SUBMIT THROUGH ADJUSTMENT OR REPLACEMENT 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.	**25**	Entity not approved.
620	**VACCINE REQUIRES 2 DIGIT MODIFIER IN BLOCK 24D. REFILE CLAIM AND VERIFY IF VACCINE IS FREE OR PURCHASED, DOSE NO. IN SERIES, OR IF CONTRAINDICATED. THANKS FOR REPORTING VACCINE**	**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.
620	**VACCINE REQUIRES 2 DIGIT MODIFIER IN BLOCK 24D. REFILE CLAIM AND VERIFY IF VACCINE IS FREE OR PURCHASED, DOSE NO. IN SERIES, OR IF CONTRAINDICATED. THANKS FOR REPORTING VACCINE**	**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.	**453**	Procedure code modifier(s) for service(s) rendered.
621	**DATE OF NEXT HEALTH CHECK SCREENING MISSING, INVALID OR NOT IN REQUIRED MM-DD-YY FORMAT IN BLOCK 15 OF CMS 1500 CLAIM FORM**	**125**	Submission-billing error(s)	**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.
621	**DATE OF NEXT HEALTH CHECK SCREENING MISSING, INVALID OR NOT IN REQUIRED MM-DD-YY FORMAT IN BLOCK 15 OF CMS 1500 CLAIM FORM**	**125**	Submission-billing error(s)	**N78**	The necessary components of the child and teen checkup (EPSDT) were not completed.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

621	**DATE OF NEXT HEALTH CHECK SCREENING MISSING, INVALID OR NOT IN REQUIRED MM-DD-YY FORMAT IN BLOCK 15 OF CMS 1500 CLAIM FORM**	**125**	Submission-billing error(s)	**N29**	Missing documentation-orders-notes- summary- report- chart.	**187**	Date(s) of service.
621	**DATE OF NEXT HEALTH CHECK SCREENING MISSING, INVALID OR NOT IN REQUIRED MM-DD-YY FORMAT IN BLOCK 15 OF CMS 1500 CLAIM FORM**	**125**	Submission-billing error(s)	**N78**	The necessary components of the child and teen checkup (EPSDT) were not completed.	**187**	Date(s) of service.
622	**NEXT SCREENING DATE IS CALCULATED TOO FAR IN THE FUTURE FOR THE RECIPIENT'S AGE AT THIS DATE OF SERVICE**	**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.
622	**NEXT SCREENING DATE IS CALCULATED TOO FAR IN THE FUTURE FOR THE RECIPIENT'S AGE AT THIS DATE OF SERVICE**	**125**	Submission-billing error(s)	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**187**	Date(s) of service.
622	**NEXT SCREENING DATE IS CALCULATED TOO FAR IN THE FUTURE FOR THE RECIPIENT'S AGE AT THIS DATE OF SERVICE**	**125**	Submission-billing error(s)	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**259**	Frequency of service.
623	**Epidural code 62278-62279 has been paid on a separate claim. Payment for W8208-00955 includes the epidural. 62278-62279 must be recouped to pay W8208-00955. Please file adjustment.**	**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.

624	**DUPLICATE PROCEDURE. PAID TO YOUR OFFICE FOR A DIFFERENT DATE OF SERVICE**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
625	**ALLOW FULL MOUTH SURVEY ONCE EVERY FIVE YEARS 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.	**259**	Frequency of service.
625	**ALLOW FULL MOUTH SURVEY ONCE EVERY FIVE YEARS PER STATE 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.
626	**EXCEEDS MAXIMUM ALLOWED FOR INTRAORAL FILMS**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within	**259**	Frequency of service.
					between this service-procedure-		

628	**ALLOW ONE HYPERBARIC OXYGEN THERAPY PER 30 DAYS**	**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	**612**	Per Day Limit Amount
629	**ALLOW 1 SERVICE-DAY FOR DIV OF SERV FOR BLIND**	**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.
629	**ALLOW 1 SERVICE-DAY FOR DIV OF SERV FOR BLIND**	**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
630	**ONLY TWO VISITS ALLOWED PER 365 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	**259**	Frequency of service.
					between this service-procedure-		

635	**ONE VENIPUNCTURE FOR SPECIMEN COLLECTION 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
636	**ONE CATHETERIZATION FOR COLLECTION 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.
636	**ONE CATHETERIZATION FOR COLLECTION 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
637	**ONE CATARACT SURGERY PROCEDURE 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.
637	**ONE CATARACT SURGERY PROCEDURE 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
638	**ONE CATARACT PROCEDURE 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.
638	**ONE CATARACT PROCEDURE 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
639	**Follow-up allowed only twice in a life time.**	**149**	Lifetime benefit maximum has been reached for this service-benefit category	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
640	**Procedure allowed once in a life time.**	**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.
641	**Rebill using y5576 for both eyes.**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

642	**Rebill using single eye follow up code Y5575.**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
643	**Only one annual physical allowed per year.**	**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.
644	**PHYSICIAN ATTENDANCE LIMIT ONE 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.
644	**PHYSICIAN ATTENDANCE LIMIT ONE 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
645	**ONLY 5 HRS OF PSYCH-C S-NEURO-COGNITIVE-MENTAL-SPEECH TESTING ALLOWED PER DAY. ONE UNIT=1HOUR. IF BILLING MORE THAN 5 HRS SUBMIT ADJUSTMENT REQUEST WITH DOCUMENTATION OF TIME**	**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.	**259**	Frequency of service.
645	**ONLY 5 HRS OF PSYCH-C S-NEURO-COGNITIVE-MENTAL-SPEECH TESTING ALLOWED PER DAY. ONE UNIT=1HOUR. IF BILLING MORE THAN 5 HRS SUBMIT ADJUSTMENT REQUEST WITH DOCUMENTATION OF TIME**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**N29**	Missing documentation-orders-notes-summary-report-chart.	**259**	Frequency of service.

645	**ONLY 5 HRS OF PSYCH-C S-NEURO-COGNITIVE-MENTAL-SPEECH TESTING ALLOWED PER DAY. ONE UNIT=1HOUR. IF BILLING MORE THAN 5 HRS SUBMIT ADJUSTMENT REQUEST WITH DOCUMENTATION OF TIME**	**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.	**263**	Length of time for services rendered.
645	**ONLY 5 HRS OF PSYCH-C S-NEURO-COGNITIVE-MENTAL-SPEECH TESTING ALLOWED PER DAY. ONE UNIT=1HOUR. IF BILLING MORE THAN 5 HRS SUBMIT ADJUSTMENT REQUEST WITH DOCUMENTATION OF TIME**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**N29**	Missing documentation-orders-notes-summary-report-chart.	**263**	Length of time for services rendered.
645	**ONLY 5 HRS OF PSYCH-C S-NEURO-COGNITIVE-MENTAL-SPEECH TESTING ALLOWED PER DAY. ONE UNIT=1HOUR. IF BILLING MORE THAN 5 HRS SUBMIT ADJUSTMENT REQUEST WITH DOCUMENTATION OF TIME**	**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.	**612**	Per Day Limit Amount
645	**ONLY 5 HRS OF PSYCH-C S-NEURO-COGNITIVE-MENTAL-SPEECH TESTING ALLOWED PER DAY. ONE UNIT=1HOUR. IF BILLING MORE THAN 5 HRS SUBMIT ADJUSTMENT REQUEST WITH DOCUMENTATION OF TIME**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**N29**	Missing documentation-orders-notes-summary-report-chart.	**612**	Per Day Limit Amount

646	**Tympanostomy includes myringotomy procedure paid previously. Resubmit as an adjustment.**	**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.
647	**Myringotomy included in tympanostomy code 69436 previously paid.**	**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.
648	**Allow procedure once per lifetime without prior approval.**	**149**	Lifetime benefit maximum has been reached for this service-benefit category	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
649	**Ventilation assist management includes cpap and-or cnp already paid.**	**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.
650	**Cpap-cnp included in ventilation assist management already paid.**	**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.

651	**Repair-replacement of pacemaker previously paid for this date of 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.
652	**Services included in pacemaker insertion previously paid on this date of 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.	**54**	Duplicate of a previously processed claim-line.
653	**Private duty nursing not allowed same day as HIT self-administered drugs. HIT payments are being recouped.**	**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.
654	**Temporary closure of eyelids by suture included in fee for eye surgery same day.**	**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.

655	**ONLY ONE HEALTH CHECK SCREENING OR INTERPERIODIC SCREEN ALLOWED PER DATE OF SERVICE, SAME OR DIFFERENT PROVIDER**	**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.
655	**ONLY ONE HEALTH CHECK SCREENING OR INTERPERIODIC SCREEN ALLOWED PER DATE OF SERVICE, SAME OR DIFFERENT PROVIDER**	**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.	**612**	Per Day Limit Amount
656	**ONLY ONE ELECTROENCEPHALOG-RAM ALLOWED PER 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.

656	**ONLY ONE ELECTROENCEPHALOG-RAM ALLOWED PER 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
657	**HITself administered drugs not allowed same day as IV pole.**	**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.
658	**Initial supply of batteries included in dispensing fee for new hearing aid-aids.**	**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.
659	**HIT self-administered drugs not allowed same day as private duty nursing.**	**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.

660	**IV-pole not allowed same day as HIT self administered drugs.**	**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.
661	**Only allowable y code services with residential treatment are Case Management and outpatient treatments.**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
661	**Only allowable y code services with residential treatment are Case Management and outpatient treatments.**	**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.
662	**Influenza or pneumococcal vaccine not covered for recipients 21 years or older for date of service prior to 10-01-93 .**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N30**	Patient ineligible for this service.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
662	**Influenza or pneumococcal vaccine not covered for recipients 21 years or older for date of service prior to 10-01-93 .**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N30**	Patient ineligible for this service.	**187**	Date(s) of service.
663	**Procedure code w8211 no longer valid on or after 06-01-93.**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N302**	Missing-incomplete-invalid other procedure date(s).	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

663	**Procedure code w8211 no longer valid on or after 06-01-93.**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N302**	Missing-incomplete-invalid other procedure date(s).	**187**	Date(s) of service.
663	**Procedure code w8211 no longer valid on or after 06-01-93.**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N302**	Missing-incomplete-invalid other procedure date(s).	**454**	Procedure code for services rendered.
664	**Newborn screening not allowed same day as Health Check screen or office visit.**	**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	**258**	Days-units for procedure-revenue code.
665	**Influenza and pneumococcal vaccines for recipients 21 years and older must be billed with the appropriate diagnosis.**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**254**	Primary diagnosis code.
665	**Influenza and pneumococcal vaccines for recipients 21 years and older must be billed with the appropriate diagnosis.**	**125**	Submission-billing error(s)	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**254**	Primary diagnosis code.
666	**Previously submitted consent has been approved with a different DOS. Submit corrected ECS claim or correct consent and resubmit with claim and records as an adjustment**	**16**	Claim-service lacks information which is needed for adjudication	**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.

666	**Previously submitted consent has been approved with a different DOS. Submit corrected ECS claim or correct consent and resubmit with claim and records as an adjustment**	**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.
666	**Previously submitted consent has been approved with a different DOS. Submit corrected ECS claim or correct consent and resubmit with claim and records as an adjustment**	**16**	Claim-service lacks information which is needed for adjudication	**MA31**	Missing-incomplete-invalid beginning and ending dates of the period billed.	**187**	Date(s) of service
666	**Previously submitted consent has been approved with a different DOS. Submit corrected ECS claim or correct consent and resubmit with claim and records as an adjustment**	**16**	Claim-service lacks information which is needed for adjudication	**N225**	Incomplete-invalid documentation-orders- notes-summary- report- chart.	**187**	Date(s) of service
667	**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.
668	**Secondary diagnosis is invalid.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**477**	Diagnosis code pointer is missing or invalid
669	**Other diagnosis code 3 is invalid.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
669	**Other diagnosis code 3 is invalid.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**477**	Diagnosis code pointer is missing or invalid.
670	**Other diagnosis code 4 is invalid.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
670	**Other diagnosis code 4 is invalid.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**477**	Diagnosis code pointer is missing or invalid.
671	**Other diagnosis code 5 is invalid.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
671	**Other diagnosis code 5 is invalid.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**477**	Diagnosis code pointer is missing or invalid.

672	**Codes Y2141 and Y2151 not payable for health departments for services on or after 7-1-93. Rebill using code 90731.**	**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	**N95**	This provider type - provider specialty may not bill this service.	**88**	Entity not eligible for benefits for submitted dates of service. Note- This code requires use of an Entity 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.	**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
674	**Y2151 is payable for health departments for ages 11-99. Rebill using Y2141.**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
675	**Other procedure code 4 must be further subdivided. (the code must have 4 digits).**	**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.
675	**Other procedure code 4 must be further subdivided. (the code must have 4 digits).**	**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

676	**Other procedure code 5 must be further subdivided. (the code must have 4 digits).**	**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.
676	**Other procedure code 5 must be further subdivided. (the code must have 4 digits).**	**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
677	**Other procedure code 6 must be further subdivided. (the code must have 4 digits).**	**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.
677	**Other procedure code 6 must be further subdivided. (the code must have 4 digits).**	**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
678	**Medicaid does not reimburse for multiple repeat sterilizations.**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**259**	Frequency of service.
679	**Verify diagnosis and procedure(s) and rebill on paper w/federal statement and records**	**11**	The diagnosis is inconsistent with the procedure. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M76**	Missing-incomplete-invalid diagnosis or condition.	**277**	Paper claim.
679	**Verify diagnosis and procedure(s) and rebill on paper w/federal statement and records**	**11**	The diagnosis is inconsistent with the procedure. 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 services billed or the date of service billed.	**277**	Paper claim.
679	**Verify diagnosis and procedure(s) and rebill on paper w/federal statement and records**	**11**	The diagnosis is inconsistent with the procedure. 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	**277**	Paper claim.

679	**Verify diagnosis and procedure(s) and rebill on paper w/federal statement and records**	**11**	The diagnosis is inconsistent with the procedure. 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	**M76**	Missing-incomplete-invalid diagnosis or condition.	**294**	Supporting documentation.
679	**Verify diagnosis and procedure(s) and rebill on paper w/federal statement and records**	**11**	The diagnosis is inconsistent with the procedure. 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 services billed or the date of service billed.	**294**	Supporting documentation.
679	**Verify diagnosis and procedure(s) and rebill on paper w/federal statement and records**	**11**	The diagnosis is inconsistent with the procedure. 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	**294**	Supporting documentation.
679	**Verify diagnosis and procedure(s) and rebill on paper w/federal statement and records**	**11**	The diagnosis is inconsistent with the procedure. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.
679	**Verify diagnosis and procedure(s) and rebill on paper w/federal statement and records**	**11**	The diagnosis is inconsistent with the procedure. 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 services billed or the date of service billed.	**488**	Diagnosis code(s) for the services rendered.
679	**Verify diagnosis and procedure(s) and rebill on paper w/federal statement and records**	**11**	The diagnosis is inconsistent with the procedure. 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	**488**	Diagnosis code(s) for the services rendered.

680	**Therapeutic abortion diagnosis code billed with non-therapeutic procedure. Correct diagnosis or procedure code and resubmit**	**11**	The diagnosis is inconsistent with the procedure. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.
680	**Therapeutic abortion diagnosis code billed with non-therapeutic procedure. Correct diagnosis or procedure code and resubmit**	**11**	The diagnosis is inconsistent with the procedure. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**N34**	Incorrect claim form-format for this service.	**488**	Diagnosis code(s) for the services rendered.
681	**Non-therapeutic abortion must be billed with appropriate diagnosis code. Correct and resubmit.**	**11**	The diagnosis is inconsistent with the procedure. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.
681	**Non-therapeutic abortion must be billed with appropriate diagnosis code. Correct and resubmit.**	**11**	The diagnosis is inconsistent with the procedure. 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	**488**	Diagnosis code(s) for the services rendered.
682	**Induced abortion procedure code must be billed with appropriate diagnosis code. Correct and resubmit on pap with records and federal abortion statement**	**11**	The diagnosis is inconsistent with the procedure. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**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.
682	**Induced abortion procedure code must be billed with appropriate diagnosis code. Correct and resubmit on pap with records and federal abortion statement**	**11**	The diagnosis is inconsistent with the procedure. 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	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

682	**Induced abortion procedure code must be billed with appropriate diagnosis code. Correct and resubmit on pap with records and federal abortion statement**	**11**	The diagnosis is inconsistent with the procedure. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M76**	Missing-incomplete-invalid diagnosis or condition.	**277**	Paper claim.
682	**Induced abortion procedure code must be billed with appropriate diagnosis code. Correct and resubmit on pap with records and federal abortion statement**	**11**	The diagnosis is inconsistent with the procedure. 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	**277**	Paper claim.
682	**Induced abortion procedure code must be billed with appropriate diagnosis code. Correct and resubmit on pap with records and federal abortion statement**	**11**	The diagnosis is inconsistent with the procedure. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M76**	Missing-incomplete-invalid diagnosis or condition.	**294**	Supporting documentation.
682	**Induced abortion procedure code must be billed with appropriate diagnosis code. Correct and resubmit on pap with records and federal abortion statement**	**11**	The diagnosis is inconsistent with the procedure. 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	**294**	Supporting documentation.
683	**Resubmit with abortion statement and records**	**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.
683	**Resubmit with abortion statement and records**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes- summary- report- chart.	**294**	Supporting documentation.
684	**Only 30 Home Health visits allowed per month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

684	**Only 30 Home Health visits allowed per month.**	**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.
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.
686	**Prior approval is required for more than 15 consecutive therapeutic leave days.**	**197**	Precertification-authorization-notification absent.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**48**	Referral-authorization.
686	**Prior approval is required for more than 15 consecutive therapeutic leave days.**	**197**	Precertification-authorization-notification absent.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**84**	Service not authorized.
687	**Health check screen or office visits are not allowed on the same day as newborn screening.**	**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.
688	**Refile with Medicare: part B buy-in is now effective for these dates of service.**	**23**	The impact of prior payer(s) adjudication including payments and-or adjustments		**No Mapping Required**	**116**	Claim submitted to incorrect payer.
689	**Claim previously submitted to Medicare with an incorrect hic number. Please correct the hic number and refile with Medicare.**	**23**	The impact of prior payer(s) adjudication including payments and-or adjustments		**No Mapping Required**	**116**	Claim submitted to incorrect payer.
690	**Please re-file with Medicare: Records indicate that someone other than Medicaid is paying Medicare part B premiums for this recipient for these dates of service.**	**22**	This care may be covered by another payer per coordination of benefits.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**107**	Processed according to contract-plan provisions.

690	**Please re-file with Medicare: Records indicate that someone other than Medicaid is paying Medicare part B premiums for this recipient for these dates of service.**	**22**	This care may be covered by another payer per coordination of benefits.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**116**	Claim submitted to incorrect payer.
691	**Medicare denied your claim for correction and-or additional information. Please refile to Medicare with the eomb correction requested.**	**23**	The impact of prior payer(s) adjudication including payments and-or adjustments		**No Mapping Required**	**116**	Claim submitted to incorrect payer.
					between this service-procedure-		

694	**Exceeds daily limit for continuous home care. Rebill using RC651.**	**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	**612**	Per Day Limit Amount
695	**One colectomy 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.
695	**One colectomy 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
696	**One colonoscopy 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.
696	**One colonoscopy 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
697	**One Home Health visit allowed per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
697	**One Home Health visit allowed per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
698	**One unit equals multiple determinations, resubmit billing only one unit.**	**125**	Submission-billing error(s)	**M53**	Missing-incomplete-invalid days or units of service.	**259**	Frequency of service.
698	**One unit equals multiple determinations, resubmit billing only one unit.**	**125**	Submission-billing error(s)	**M53**	Missing-incomplete-invalid days or units of service.	**476**	Missing or invalid units of service
699	**Exceeds one per month limitation for Case Management.**	**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.

699	**Exceeds one per month limitation for Case Management.**	**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.
700	**Use established office visit code.**	**125**	Submission-billing error(s)	**M13**	Only one initial visit is covered per specialty per medical group.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
700	**Use established office visit code.**	**125**	Submission-billing error(s)	**M13**	Only one initial visit is covered per specialty per medical	**454**	Procedure code for services rendered.
					between this service-procedure-		

703	**Rhythm strip included in 12 lead EKG.**	**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.
704	**Component of EKG previously paid this DOS. Please file adjustment.**	**97**	The benefit for this service is included in the payment-allowance for another service-	**M86**	Service denied because payment already made for similar procedure within set	**454**	Procedure code for services rendered.
					between this service-procedure-		

707	**Initial critical care allowed once per hospitalization.**	**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.
707	**Initial critical care allowed once per hospitalization.**	**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.
708	**Admission H&P allowed once per hospitalization. Transfers within the same facility do not support the billing of a new admission. Rebill appropriate level CPT E-M code.**	**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.
					between this service-procedure-		

711	**Only one epidural follow-up 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
712	**Only one epidural procedure allowed every four 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.
713	**Lupron depot limited to once every 28 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.
714	**Routine, annual or screening mammography 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.
715	**Original surgery fee includes multiple stage retinal repair.**	**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.
716	**Exceeds one per day limitation.**	**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.
716	**Exceeds one per day limitation.**	**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
717	**Cap waiver supplies limit once 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.
717	**Cap waiver supplies limit once 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

718	**Exceeds one per day limitation.**	**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.
718	**Exceeds one per day limitation.**	**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
719	**Exceeds CAP limitation for Case Management.**	**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.
719	**Exceeds CAP limitation for Case Management.**	**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.
719	**Exceeds CAP limitation for Case Management.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
719	**Exceeds CAP limitation for Case Management.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**483**	Maximum coverage amount met or exceeded for benefit period.
720	**Sterilization under both general anesthesia and epidural anesthesia not allowed on the same day. Please file an adjustment request with documentation for exceptions.**	**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.	**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.	**258**	Days-units for procedure-revenue code.

720	**Sterilization under both general anesthesia and epidural anesthesia not allowed on the same day. Please file an adjustment request with documentation for exceptions.**	**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.
720	**Sterilization under both general anesthesia and epidural anesthesia not allowed on the same day. Please file an adjustment request with documentation for exceptions.**	**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.	**N29**	Missing documentation-orders-notes- summary- report- chart.	**258**	Days-units for procedure-revenue code.
721	**Each additional lesion only allowed when billed on the same day as excision of breast lesion.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
721	**Each additional lesion only allowed when billed on the same day as excision of breast lesion.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
722	**Each additional lesion only allowed when billed on the same day as preoperative placement needle localization wire; breast.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.

722	**Each additional lesion only allowed when billed on the same day as preoperative placement needle localization wire; breast.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
723	**Exceeds one per day limitation.**	**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.
723	**Exceeds one per day limitation.**	**119**	Benefit maximum for this time	**M86**	Service denied because	**612**	Per Day Limit Amount
					between this service-procedure-		

727	**CAP limitation has been 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.
727	**CAP limitation has been 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.
727	**CAP limitation has been exceeded.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
727	**CAP limitation has been 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	**483**	Maximum coverage amount met or exceeded for benefit period.
728	**CAP limitation has been 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.
728	**CAP limitation has been 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.
728	**CAP limitation has been exceeded.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
728	**CAP limitation has been 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	**483**	Maximum coverage amount met or exceeded for benefit period.
729	**CAP limitation has been 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.

729	**CAP limitation has been 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.
729	**CAP limitation has been exceeded.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
729	**CAP limitation has been 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	**483**	Maximum coverage amount met or exceeded for benefit period.
730	**Dental exam not allowed on the same date of service as limited oral evaluation problem focused.**	**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.
731	**CAP limitation has been 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.
731	**CAP limitation has been 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.
731	**CAP limitation has been exceeded.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
731	**CAP limitation has been 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	**483**	Maximum coverage amount met or exceeded for benefit period.

732	**Gamma globulin may be billed only one time per date of service. If billing multiple units, rebill using the appropriate dose specific HCPC code.**	**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.
732	**Gamma globulin may be billed only one time per date of service. If billing multiple units, rebill using the appropriate dose specific HCPC code.**	**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
					between this service-procedure-		

736	**CAP limitation has been 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.
736	**CAP limitation has been exceeded.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
736	**CAP limitation has been 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	**483**	Maximum coverage amount met or exceeded for benefit period.
737	**CAP limitation has been 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.
737	**CAP limitation has been 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.
737	**CAP limitation has been exceeded.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
737	**CAP limitation has been 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	**483**	Maximum coverage amount met or exceeded for benefit period.
738	**One supply item 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.
738	**One supply item 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
739	**HIV Case Management daily limit has exceeded the maximum of 96 units 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.

739	**HIV Case Management daily limit has exceeded the maximum of 96 units allowed per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
739	**HIV Case Management daily limit has exceeded the maximum of 96 units 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
739	**HIV Case Management daily limit has exceeded the maximum of 96 units allowed per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount
740	**CAP limitation has been 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.
740	**CAP limitation has been 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.
740	**CAP limitation has been exceeded.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
740	**CAP limitation has been 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	**483**	Maximum coverage amount met or exceeded for benefit period.
741	**Multiple surgery for ambulatory surgical center cutback.**	**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.

741	**Multiple surgery for ambulatory surgical center cutback.**	**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
742	**Use established ER procedure**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid	**465**	Principal Procedure Code for
					between this service-procedure-		

747	**Exceeds monthly allowable for tens rental.**	**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.
747	**Exceeds monthly allowable for tens rental.**	**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.
748	**CAP limitation has been exceeded.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our	**259**	Frequency of service.
					between this service-procedure-		

752	**Allow 2 eye exams a 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.	**259**	Frequency of service.
752	**Allow 2 eye exams a year.**	**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.
753	**Second billing of the same quadrant for periodontal scaling root planning.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within	**259**	Frequency of service.
					between this service-procedure-		

755	**ESRD related services for full month must be billed using the last day of the month and one unit of service.**	**125**	Submission-billing error(s)	**M53**	Missing-incomplete-invalid days or units of service.	**476**	Missing or invalid units of service.
755	**ESRD related services for full month must be billed using the last day of the month and one unit of service.**	**125**	Submission-billing error(s)	**MA31**	Missing-incomplete-invalid beginning and ending dates of the period billed.	**476**	Missing or invalid units of service.
756	**Allow circumcision 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.
757	**Allow therapeutic apheresis once 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.
757	**Allow therapeutic apheresis once 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
758	**Allow 1 dental sealant (01351) per tooth.**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**259**	Frequency of service.
759	**Colposcopy allowed once 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.
759	**Colposcopy allowed once 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
760	**Only one diagnosis modifier allowed in block 24d per diagnosis code. 1N not allowed in conjunction with another diagnosis modifier such as 2E, etc.**	**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.	**258**	Days-units for procedure-revenue code.

761	**Ophthalmoscopy angiographies allowed six times per 365 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.
761	**Ophthalmoscopy angiographies allowed six times per 365 days.**	**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.
762	**MEDICAL NECESSITY FOR**	**50**	These are non-covered services because this is not deemed a	**N180**	This item or service does not meet the criteria for the	**287**	Medical necessity for service.
					between this service-procedure-		

768	**H-A batteries allowed six times per 365 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.
769	**Loaner hearing aid payment limit per 10 week period has been exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
769	**Loaner hearing aid payment**	**119**	Benefit maximum for this time	**N357**	Time frame requirements	**259**	Frequency of service.
					between this service-procedure-		

775	**RC 590 allowed once per day. If submitting adjustment, attach time documentation.**	**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.
775	**RC 590 allowed once per day. If submitting adjustment, attach time documentation.**	**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
776	**Allow two eye exams a year.**	**119**	Benefit maximum for this time	**M86**	Service denied because	**259**	Frequency of service.
					between this service-procedure-		

780	**Only one wais bender test allowed per six months.**	**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.
780	**Only one wais bender test allowed per six months.**	**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.
781	**Only on psychiatric interview**	**119**	Benefit maximum for this time	**M86**	Service denied because	**259**	Frequency of service.
					between this service-procedure-		

786	**Only three visual field exams allowed per year.**	**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.
787	**Lupron depot allowed 16 units per 365 days.**	**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	**259**	Frequency of service.
					between this service-procedure-		

791	**Exceeds CAP in-home aide daily limit.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
791	**Exceeds CAP in-home aide daily 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	**259**	Frequency of service.
					between this service-procedure-		

794	**Delivery under both general anesthesia and epidural anesthesia not allowed on the same day. Please file adjustment request with documentation for exceptions.**	**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	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
					between this service-procedure-		

797	**Thanks for reporting vaccine. Contraindication modifier indicates vaccine not given on date of service. Please report if vaccine given at future date.**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	**M41**	We do not pay for this as the patient has no legal obligation to pay for this.	**187**	Date(s) of service.
798	**Exceeds CAP-MR-DD-in-home aide level I daily limit.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within	**259**	Frequency of service.
					between this service-procedure-		

801	**Medical necessity for ambulance transportation is not apparent.**	**50**	These are non-covered services because this is not deemed a `medical necessity by the payer.	**N157**	Transportation to-from this destination is not covered.	**428**	Reason for transport by ambulance
802	**Allow 1 CAP phone Alert-month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
802	**Allow 1 CAP phone Alert-month.**	**119**	Benefit maximum for this time period or occurrence has been	**N357**	Time frame requirements between this service-procedure-	**259**	Frequency of service.
					between this service-procedure-		

804	**Resubmit with anesthesia time noted on the claim.**	**152**	Payer deems the information submitted does not support this length of service. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**N203**	Missing-imcomplete-invalid anesthesia time-units.	**251**	Total anesthesia minutes.
805	**REBILL USING PERIODIC ORAL EXAMINATION CODE.**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
805	**REBILL USING PERIODIC ORAL EXAMINATION CODE.**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**239**	Dental information.
806	**Units were changed to allow a maximum of 320 units per month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
806	**Units were changed to allow a maximum of 320 units per month.**	**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.
806	**Units were changed to allow a maximum of 320 units per month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
806	**Units were changed to allow a maximum of 320 units per month.**	**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.
807	**MEDICAL NECESSITY FOR MULTIPLE FETAL CARDIOVASCULAR ULTRASOUNDS NOT APPARENT**	**50**	These are non-covered services because this is not deemed a `medical necessity by the payer.	**N180**	This item or service does not meet the criteria for the category under which it was billed	**287**	Medical necessity for service.
808	**Exceeds CAP-c daily service limit for nursing.**	**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.

808	**Exceeds CAP-c daily service limit for nursing.**	**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**	Frequency of service.
809	**Only one fetal cardiovascular ultra sound 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.
809	**Only one fetal cardiovascular ultra sound 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**	Frequency of service.
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

814	**Office visit included in fee for iud.**	**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.
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
					between this service-procedure-		

817	**Services are not to be billed spanning multiple calendar months. Rebill with dates of service within one month only.**	**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.
817	**Services are not to be billed spanning multiple calendar months. Rebill with dates of service within one month only.**	**125**	Submission-billing error(s)	**M53**	Missing-incomplete-invalid days or units of service.	**187**	Date(s) of service.
817	**Services are not to be billed spanning multiple calendar months. Rebill with dates of service within one month only.**	**125**	Submission-billing error(s)	**MA31**	Missing-incomplete-invalid beginning and ending dates of the period billed.	**187**	Date(s) of service.
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.

820	**Submit as adjustment with legible documentation/attachments**	**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.
821	**Full recoupment, all outpatient charges are included in per diem payment.**	**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.
822	**The consent form has an incomplete address. Please complete the address by adding street, city, state, and zip**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form..	**123**	Additional information requested from entity.
823	**THE CONSENT/STATEMENT IS INCOMPLETE. COMPLETE ALL BLANK SPACES WITH APPROPRIATE INFORMATION**	**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.
823	**THE CONSENT/STATEMENT IS INCOMPLETE. COMPLETE ALL BLANK SPACES WITH APPROPRIATE INFORMATION**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form..	**297**	Medical notes/report.
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.

825	**IUD included fee for office visit.**	**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	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
					between this service-procedure-		

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**	**76**	Disproportionate Share		**No Mapping Required**	**104**	Processed according to plan
					between this service-procedure-		

833	**DME procedure allowed once in five 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.
834	**This previously paid claim has been recouped and repaid in this check write to include the**	**76**	Disproportionate Share Adjustment.		**No Mapping Required**	**104**	Processed according to plan provisions.
					between this service-procedure-		

836	**Fludara (fludarabine phosphate) limited to 2 dosages per day (50 mg each).**	**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	**612**	Per Day Limit Amount
837	**Heel wedge limited to two per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
					between this service-procedure-		

840	**Exceeds daily limit for At-Risk Case Management (adult).**	**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	**612**	Per Day Limit Amount
841	**Exceeds daily limit for At-Risk Case Management (child).**	**119**	Benefit maximum for this time period or occurrence has been	**M86**	Service denied because payment already made for	**259**	Frequency of service.
					between this service-procedure-		

844	**DME equipment allowed once in three years.**	**18**	18 - Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
845	**DME equipment allowed once in five years.**	**119**	Benefit maximum for this time period or occurrence has been	**M86**	Service denied because payment already made for	**259**	Frequency of service.
					between this service-procedure-		

849	**Payment reduced to equal new purchase price. Medicaid has previously paid for this equipment code.**	**108**	Rent-purchase guidelines were not met. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M7**	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.	**186**	Purchase and rental price of durable medical equipment.
849	**Payment reduced to equal new purchase price. Medicaid has previously paid for this equipment code.**	**108**	Rent-purchase guidelines were not met. 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	**186**	Purchase and rental price of durable medical equipment.
850	**Medicaid has paid maximum allowable for this equipment code.**	**108**	Rent-purchase guidelines were not met. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M7**	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.	**186**	Purchase and rental price of durable medical equipment.
850	**Medicaid has paid maximum allowable for this equipment code.**	**108**	Rent-purchase guidelines were not met. 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	**186**	Purchase and rental price of durable medical equipment.
851	**DME equipment allowed once in three years.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
852	**DME equipment allowed once in three years.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
853	**DME equipment allowed once in three years.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
854	**DME equipment allowed once in three years.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

855	**DME equipment allowed once in three years.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
856	**DME equipment allowed once in three years.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
857	**DME equipment allowed once in three years.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
858	**DME equipment allowed once 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.
858	**DME equipment allowed once 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
859	**DME equipment allowed once 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.
859	**DME equipment allowed once 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
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.
861	**DME equipment allowed once 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.
861	**DME equipment allowed once 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

862	**DME equipment allowed once 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.
862	**DME equipment allowed once 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
863	**HYSTERECTOMY STATEMENT DOES NOT MEET FEDERAL GUIDELINES, RESUBMIT NEWLY OBTAINED STATEMENT**	**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.
863	**HYSTERECTOMY STATEMENT DOES NOT MEET FEDERAL GUIDELINES, RESUBMIT NEWLY OBTAINED STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**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.
863	**HYSTERECTOMY STATEMENT DOES NOT MEET FEDERAL GUIDELINES, RESUBMIT NEWLY OBTAINED STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**297**	Medical notes/report.
863	**HYSTERECTOMY STATEMENT DOES NOT MEET FEDERAL GUIDELINES, RESUBMIT NEWLY OBTAINED STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information**.**	**297**	Medical notes/report.
864	**HYSTERECTOMY STATEMENT RECEIVED ILLEGIBLE. RESUBMIT A LEGIBLE STATEMENT**	**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.

864	**HYSTERECTOMY STATEMENT RECEIVED ILLEGIBLE. RESUBMIT A LEGIBLE STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N205**	Information provider was illegible.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
864	**HYSTERECTOMY STATEMENT RECEIVED ILLEGIBLE. RESUBMIT A LEGIBLE STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**297**	Medical notes/report.
864	**HYSTERECTOMY STATEMENT RECEIVED ILLEGIBLE. RESUBMIT A LEGIBLE STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N205**	Information provider was illegible.	**297**	Medical notes/report.
865	**WRONG HYSTERECTOMY STATEMENT SENT. RESUBMIT THE 'PRIOR TO' STATEMENT.**	**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.
865	**WRONG HYSTERECTOMY STATEMENT SENT. RESUBMIT THE 'PRIOR TO' STATEMENT.**	**16**	Claim-service lacks information which is needed for adjudication	**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.
865	**WRONG HYSTERECTOMY STATEMENT SENT. RESUBMIT THE 'PRIOR TO' STATEMENT.**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**297**	Medical notes/report.
865	**WRONG HYSTERECTOMY STATEMENT SENT. RESUBMIT THE 'PRIOR TO' STATEMENT.**	**16**	Claim-service lacks information which is needed for adjudication	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information.	**297**	Medical notes/report.
866	**DOS is incorrect or missing on the hysterectomy statement correct DOS on statement, initial date correction & resubmit as adjustment with claim, statement & operative record**	**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.

866	**DOS is incorrect or missing on the hysterectomy statement correct DOS on statement, initial date correction & resubmit as adjustment with claim, statement & operative record**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**187**	Date(s) of service
866	**DOS is incorrect or missing on the hysterectomy statement correct DOS on statement, initial date correction & resubmit as adjustment with claim, statement & operative record**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**298**	Operative report
867	**Verify hysterectomy procedure, correct your claim and resubmit as an adjustment with operative records for documentation, i.e. one says abdominal hyster, the other says vaginal**	**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.
867	**Verify hysterectomy procedure, correct your claim and resubmit as an adjustment with operative records for documentation, i.e. one says abdominal hyster, the other says vaginal**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart.	**298**	Operative report
867	**Verify hysterectomy procedure, correct your claim and resubmit as an adjustment with operative records for documentation, i.e. one says abdominal hyster, the other says vaginal**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart.	**454**	Procedure code for services rendered.

868	**Verify date of service, correct your claim & resubmit as an adjustment with operative records for documentation, i.e., Date on claim differs from date on statement**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart.	**187**	Date(s) of service.
868	**Verify date of service, correct your claim & resubmit as an adjustment with operative records for documentation, i.e., Date on claim differs from date on statement**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart.	**298**	Operative report.
869	**ILLEGIBLE WITNESS AND/OR PATIENT SIGNATURE ON HYSTERECTOMY STATEMENT. PLEASE INDENTIFY SIGNATURE AND RESUBMIT**	**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.
869	**ILLEGIBLE WITNESS AND/OR PATIENT SIGNATURE ON HYSTERECTOMY STATEMENT. PLEASE INDENTIFY SIGNATURE AND RESUBMIT**	**16**	Claim-service lacks information which is needed for adjudication	**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.
869	**ILLEGIBLE WITNESS AND/OR PATIENT SIGNATURE ON HYSTERECTOMY STATEMENT. PLEASE INDENTIFY SIGNATURE AND RESUBMIT**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**297**	Medical notes/report.
869	**ILLEGIBLE WITNESS AND/OR PATIENT SIGNATURE ON HYSTERECTOMY STATEMENT. PLEASE INDENTIFY SIGNATURE AND RESUBMIT**	**16**	Claim-service lacks information which is needed for adjudication	**N205**	Information provided was illegible.	**297**	Medical notes/report.

870	**Personal Care Services not allowed the same day as CAP In-Home Level II and In-Home Level III.**	**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.	**N205**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
871	**CAP In-Home Level II and In-Home Level III not allowed same day as Personal Care Services.**	**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.	**N205**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
872	**I&D included in previously paid appendectomy.**	**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.
873	**Catherization included in dilation.**	**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.

874	**Multiple ER visits not allowed same DOS, same provider specialty. File adjustment if visits were separate occasions.**	**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.
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.
876	**Facility fee For labor care previously paid.**	**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.
877	**Labor care included in previously paid delivery.**	**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.
878	**Episiotomy included in vaginal delivery.**	**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.

879	**Physician charge denied same DOS as facility billing.**	**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.	**N205**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
880	**Facility charge denied same DOS as physician billing.**	**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.
881	**EMG one extremity 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.
881	**EMG one extremity 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
882	**One EMG two extremities 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.
882	**One EMG two extremities 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
883	**EMG three extremities allowed once 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.

883	**EMG three extremities allowed once 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
884	**Rebill adjustment with records documenting units.**	**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.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
884	**Rebill adjustment with records documenting units.**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**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.
885	**Rebill adjustment with records documenting units.**	**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.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
885	**Rebill adjustment with records documenting units.**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**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.
886	**Exceeds the limit of six units per day for reflex study.**	**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.
886	**Exceeds the limit of six units per day for reflex study.**	**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
887	**DME equipment allowed once 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.

887	**DME equipment allowed once 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
888	**Coverage for these new CPT codes are still under evaluation. Please do not rebill until notified through your bulletin.**	**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.
889	**MEDICARE COVERED DAYS ARE MISSING OR INVALID. REFILE PAPER CLAIM WITH MEDICARE EOB**	**148**	Information from another provider was not provided or was insufficient-incomplete	**N4**	Missing-incomplete-invalid prior insurance carrier EOB.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
889	**MEDICARE COVERED DAYS ARE MISSING OR INVALID. REFILE PAPER CLAIM WITH MEDICARE EOB**	**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.
889	**MEDICARE COVERED DAYS ARE MISSING OR INVALID. REFILE PAPER CLAIM WITH MEDICARE EOB**	**148**	Information from another provider was not provided or was insufficient-incomplete	**N4**	Missing-incomplete-invalid prior insurance carrier EOB.	**456**	Covered Day(s)
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
891	**Self-administered drugs limited to once 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.

891	**Self-administered drugs limited to once 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
892	**Units cut back. Lab results do not support necessity for more than 14 units EPO per day.**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
892	**Units cut back. Lab results do not support necessity for more than 14 units EPO per day.**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**258**	Days-units for procedure-revenue code.
892	**Units cut back. Lab results do not support necessity for more than 14 units EPO per day.**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
892	**Units cut back. Lab results do not support necessity for more than 14 units EPO per day.**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**259**	Frequency of service.
892	**Units cut back. Lab results do not support necessity for more than 14 units EPO per day.**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
892	**Units cut back. Lab results do not support necessity for more than 14 units EPO per day.**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**612**	Per Day Limit Amount
893	**MEDICAL NECESSITY NOT APPARENT FOR CRTICAL CARE/PROLONGED SERVICES AND CONSULTS ON THE SAME DAY**	**50**	These are non-covered services because this is not deemed a `medical necessity by the payer.	**N180**	This item or service does not meet the criteria for the category under which it was billed	**258**	Days-units for procedure-revenue code.

893	**MEDICAL NECESSITY NOT APPARENT FOR CRTICAL CARE/PROLONGED SERVICES AND CONSULTS ON THE SAME DAY**	**50**	These are non-covered services because this is not deemed a `medical necessity by the payer.	**N180**	This item or service does not meet the criteria for the category under which it was billed	**287**	Medical necessity for service.
894	**Prolonged services and critical care not allowed same date of service.**	**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.	**N205**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
895	**Exceeds daily limit for termination allowance.**	**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	**259**	Frequency of service.
895	**Exceeds daily limit for termination allowance.**	**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	**612**	Per Day Limit Amount
896	**Additional procedure same date of service paid at 50 percent of allowable.**	**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.

896	**Additional procedure same date of service paid at 50 percent of allowable.**	**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
897	**TCD included in fee for surgery.**	**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.
898	**Newborn resuscitation only payable on date of delivery. Rebill using appropriate level hospital visit or critical care code.**	**150**	Payer deems the information submitted does not support this level of service	**M13**	Only one initial visit is covered per specialty per medical group.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
899	**Units cutback. maximum number of units per day exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
899	**Units cutback. maximum number of units per day exceeded.**	**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.
899	**Units cutback. maximum number of units per day exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
899	**Units cutback. maximum number of units per day exceeded.**	**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.

899	**Units cutback. maximum number of units per day exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
899	**Units cutback. maximum number of units per day exceeded.**	**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	**612**	Per Day Limit Amount
900	**Claim denied for lack of requested information.**	**125**	Submission-billing error(s)	**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.
900	**Claim denied for lack of requested information.**	**125**	Submission-billing error(s)	**N29**	Missing documentation-orders-notes- summary- report- chart.	**95**	Requested additional information not received.
901	**No adjustment due.**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement		**No Mapping Required**		104 - Processed according to plan provisions.
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.
905	**Drug not covered under rebate agreement.**	**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.
906	**Cervical braces allowed once in 18 months.**	**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.
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.
908	**Refer to your 1992 CPT book and rebill.**	**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.

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.
913	**Rebill your claim using the correct consultation code(s).**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
913	**Rebill your claim using the correct consultation code(s).**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**454**	Procedure code for services rendered.

914	**Dispensing fees for accessories are included in the dispensing fee for a new aid-aids.**	**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.
915	**A component of the EKG has paid on a previous claim. File adjustment of that claim, combine charges and code to all inclusive EKG 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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
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.
917	**The consent form is completed incorrectly. Please correct by eliminating abbreviations in the clinic-doctor name spaces.**	**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.
917	**The consent form is completed incorrectly. Please correct by eliminating abbreviations in the clinic-doctor name spaces.**	**16**	Claim-service lacks information which is needed for adjudication	**N252**	Missing-incomplete-invalid attending provider name.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

918	**The consent form is completed incorrectly. Please correct by placing the recipients full name in the "name of individual" space.**	**16**	Claim-service lacks information which is needed for adjudication	**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.
918	**The consent form is completed incorrectly. Please correct by placing the recipients full name in the "name of individual" space.**	**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.
918	**The consent form is completed incorrectly. Please correct by placing the recipients full name in the "name of individual" space.**	**16**	Claim-service lacks information which is needed for adjudication	**MA36**	Missing-incomplete-invalid patient name.	**124**	Entitys name, address, phone and id number
918	**The consent form is completed incorrectly. Please correct by placing the recipients full name in the "name of individual" space.**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**124**	Entitys name, address, phone and id number
919	**The recipient date of birth on record is different from consent form. Please correct the DOB field on the consent form and resubmit.**	**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.
919	**The recipient date of birth on record is different from consent form. Please correct the DOB field on the consent form and resubmit.**	**16**	Claim-service lacks information which is needed for adjudication	**N329**	Missing-incomplete-invalid patient birth date.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
919	**The recipient date of birth on record is different from consent form. Please correct the DOB field on the consent form and resubmit.**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**158**	Entitys date of birth

919	**The recipient date of birth on record is different from consent form. Please correct the DOB field on the consent form and resubmit.**	**16**	Claim-service lacks information which is needed for adjudication	**N329**	Missing-incomplete-invalid patient birth date.	**158**	Entitys date of birth
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
921	**Service denied: the dispensing fee for accessories that is included in disp. fee for new hearing aid(s) has been paid for this date of 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.
922	**Claim suspended due to court order.**	**133**	The disposition of this claim-service is pending further review.		**No Mapping Required**	**40**	Waiting for final approval.

923	**Consultation and emergency room visit not allowed on same DOS, same provider specialty.**	**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.
924	**Emergency room visit and consultation not allowed on same DOS, same provider specialty.**	**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.
925	**Admit date and 'from' date of service not consistent with 3rd digit-frequency code of bill type. Enter correct bill type, admit date or 'from' DOS and submit as a new claim.**	**125**	Submission-billing error(s)	**MA30**	Missing-incomplete-invalid type of bill. .	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
925	**Admit date and 'from' date of service not consistent with 3rd digit-frequency code of bill type. Enter correct bill type, admit date or 'from' DOS and submit as a new claim.**	**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.
925	**Admit date and 'from' date of service not consistent with 3rd digit-frequency code of bill type. Enter correct bill type, admit date or 'from' DOS and submit as a new claim.**	**125**	Submission-billing error(s)	**MA30**	Missing-incomplete-invalid type of bill. .	**189**	Facility admission date

925	**Admit date and 'from' date of service not consistent with 3rd digit-frequency code of bill type. Enter correct bill type, admit date or 'from' DOS and submit 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
926	**Services billed under routine diagnosis 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.	**N115**	This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD). An LMRP-LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http--- www.cms.hhs.gov-mcd, or if you do not have web access, you may contact the contractor to request a copy of the LMRP-LCD	**488**	Diagnosis code(s) for the services rendered
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
928	**Injection of antigen is included in the fee for allergenic immunotherapy with provision of allergenic extract already paid for this date of 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.

929	**Injection of antigen has already been paid for this date of service. Rebill using code for provision of allergenic extract 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**54**	Duplicate of a previously processed claim-line.
930	**Any combination of periodontal and prophy allowed on same date of service.**	**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.
931	**Patient must be eligible on banding date and banding claim.**	**177**	Patient has not met the required eligibility requirements.	**N30**	Patient ineligible for this service.	**90**	Entity not eligible for medical benefits for submitted dates of service. Note- This code requires use of an Entity Code.
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
933	**Related Depo-Provera injections not allowed same day, same or different provider**	**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.
934	**Related Depo-Provera injections not allowed same day, same or different provider**	**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.
935	**Skilled nurse home visit not allowed same DOS as related 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.

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
937	**Maternity care not allowed same date of service as related 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.
938	**Postpartum-newborn home visit not allowed with related procedure, same date of service.**	**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.

939	**Maternity care-newborn visit not allowed same DOS as skilled nurse maternal care home visit.**	**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.
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**	Entitys name.
941	**Prescription number required.**	**125**	Submission-billing error(s)	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**219**	Prescription number.
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**	Entitys 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.

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	**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.
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).	**221**	Drug days supply and dosage.
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	**M123**	Missing-incomplete-invalid name, strength, or dosage of the drug furnished.	**221**	Drug days supply and dosage.
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.

952	**Fixation of femur fracture included in hemiarthroplasty, hip partial.**	**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.
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
956	**Comprehensive evaluation and related components not allowed on the same DOS, same or different provider.**	**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.
957	**Dialysis treatment allowed once per day. If more than one treatment is provided submit an adjustment with documentation showing medical necessity.**	**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.

957	**Dialysis treatment allowed once per day. If more than one treatment is provided submit an adjustment with documentation showing medical necessity.**	**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
958	**Units cut back;only one unit allowed per day. If multiple unrelated tests were performed, file as an adjustment.**	**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.
958	**Units cut back;only one unit allowed per day. If multiple unrelated tests were performed, file as an adjustment.**	**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
959	**Maximum number of units per day previously paid for this date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
959	**Maximum number of units per day previously paid for this date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N20**	Service not payable with other service rendered on the same date.	**612**	Per Day Limit Amount
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).

961	**Newborn Health Check screen and Newborn Assessment not allowed on the 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.
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.
963	**Childbirth classes and refresher classes not allowed on the 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.
964	**1993 Adult health assessment code not allowed with related codes(Y2000;Y2133;W8001).**	**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.

965	**Related procedure not allowed same day as Y2039.**	**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.
966	**Only one Fetal non-stress test allowed-day. Detail has been cut back to allow one unit.**	**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.
967	**DHS immunizations cannot be assigned a family planning category of service; no family planning cos exists for required financial treatment.**	**150**	Payer deems the information submitted does not support this level of service	**N180**	This item or service does not meet the criteria for the category under which it was billed	**454**	Procedure code for services rendered.
968	**Records indicate claim should be processed as a therapeutic abortion. Resubmit w/appropriate 5 digit diagnosis code from the 635-635.9 range of codes & federal abortion statement.**	**11**	The diagnosis is inconsistent with the procedure.	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered
969	**Records indicate this is not a therapeutic abortion. Please remove the therapeutic abortion code and resubmit with a corrected 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
969	**Records indicate this is not a therapeutic abortion. Please remove the therapeutic abortion code and resubmit with a corrected diagnosis code.**	**11**	The diagnosis is inconsistent with the procedure.	**M76**	Missing-incomplete-invalid diagnosis or condition.	**454**	Procedure code for services rendered

970	**A therapeutic abortion procedure is not billed on this claim. Please remove the therapeutic diagnosis code from your claim and resubmit.**	**11**	The diagnosis is inconsistent with the procedure.	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered
971	**Periodontal maintenance procedures are allowed only as follow-up to periodontal surgery.**	**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
971	**Periodontal maintenance procedures are allowed only as follow-up to periodontal surgery.**	**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.	**N188**	The approved level of care does not match the procedure code submitted	**454**	Procedure code for services rendered
972	**Over 3 hours of physician unusual travel must be documented. Resubmit claim with records.**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes- summary- report- chart.	**263**	Length of time for services rendered.
972	**Over 3 hours of physician unusual travel must be documented. Resubmit claim with records.**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes- summary- report- chart.	**294**	Supporting documentation
973	**Non-emergent ambulance:one-way transportation and round trip transportation are not allowed on the 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.

974	**Code invalid for this DOS.**	**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.
974	**Code invalid for this DOS.**	**125**	Submission-billing error(s)	**MA31**	Missing-incomplete-invalid beginning and ending dates of the period billed.	**187**	Date(s) of service.
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
981	**Non-emergent transport paid for "specialized services" only. Please document service rendered requiring transport and resubmit as an adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes- summary- report- chart.	**428**	Reason for transport by ambulance
982	**Payment for outpatient place of service reduced to 80% of fee 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	**249**	Place of service.
983	**Repeat medication professional fee denied.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
984	**Non-emergent transport paid only for specialized services that cannot be provided in the place of residence.**	**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.	**M77**	Missing-incomplete-invalid place of service.	**249**	Place of service.
984	**Non-emergent transport paid only for specialized services that cannot be provided in the place of residence.**	**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.	**M77**	Missing-incomplete-invalid place of service.	**454**	Procedure code for services rendered.

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.
986	**Primary procedure code is invalid.**	**125**	Submission-billing error(s)	**N56**	Procedure code billed is not correct-valid for the service 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.
986	**Primary procedure code is invalid.**	**125**	Submission-billing error(s)	**N56**	Procedure code billed is not correct-valid for the service billed or the date of service billed.	**465**	Principal Procedure Code for Service(s) Rendered
987	**Other procedure code 2 is invalid.**	**125**	Submission-billing error(s)	**N56**	Procedure code billed is not correct-valid for the service 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.
987	**Other procedure code 2 is invalid.**	**125**	Submission-billing error(s)	**N56**	Procedure code billed is not correct-valid for the service billed or the date of service billed.	**490**	Other procedure code for service(s) rendered
988	**Other procedure code 3 is invalid.**	**125**	Submission-billing error(s)	**N56**	Procedure code billed is not correct-valid for the service 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.
988	**Other procedure code 3 is invalid.**	**125**	Submission-billing error(s)	**N56**	Procedure code billed is not correct-valid for the service billed or the date of service billed.	**490**	Other procedure code for service(s) rendered
989	**Primary procedure code must be further subdivided. (The code must have four digits).**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

989	**Primary procedure code must be further subdivided. (The code must have four digits).**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**465**	Principal Procedure Code for Service(s) Rendered
990	**Other procedure code 2 must be further subdivided. (The code must have 4 digits).**	**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.
990	**Other procedure code 2 must be further subdivided. (The code must have 4 digits).**	**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
991	**Other procedure code 3 must be further subdivided (the code must have 4 digits).**	**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.
991	**Other procedure code 3 must be further subdivided (the code must have 4 digits).**	**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
992	**CPT 90741 may not be billed for dates of service on or after 01-01-1994. Please rebill using the appropriate, dose specific HCPC code (J1460-J1561).**	**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.
992	**CPT 90741 may not be billed for dates of service on or after 01-01-1994. Please rebill using the appropriate, dose specific HCPC code (J1460-J1561).**	**125**	Submission-billing error(s)	**N56**	Procedure code billed is not correct-valid for the services billed or the date of service billed.	**187**	Date(s) of service.
993	**Exceeds limitations per 365 days, submit as an adjustment**	**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.

993	**Exceeds limitations per 365 days, submit as an adjustment**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N435**	Exceeds number-frequency approved -allowed within time period without support documentation.	**259**	Frequency of service.
993	**Exceeds limitations per 365 days, submit as an adjustment**	**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.	**287**	Medical necessity for service.
993	**Exceeds limitations per 365 days, submit as an adjustment**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N435**	Exceeds number-frequency approved -allowed within time period without support documentation.	**287**	Medical necessity for service.
993	**Exceeds limitations per 365 days, submit as an adjustment**	**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.	**294**	Supporting documentation.
993	**Exceeds limitations per 365 days, submit as an adjustment**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N435**	Exceeds number-frequency approved -allowed within time period without support documentation.	**294**	Supporting documentation.
994	**UP TO 3 ROUTES ALLOWED FOR CHEMOTHERAPY ADMINISTRATION. IF MORE THAN 3 ROUTES REQUIRED, SUBMIT AS AN ADJUSTMENT WITH MEDICAL RECORDS DOUCUMENTING SERVICES**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**N29**	Missing documentation-orders-notes-summary-report-chart.	**259**	Frequency of service.
994	**UP TO 3 ROUTES ALLOWED FOR CHEMOTHERAPY ADMINISTRATION. IF MORE THAN 3 ROUTES REQUIRED, SUBMIT AS AN ADJUSTMENT WITH MEDICAL RECORDS DOUCUMENTING SERVICES**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**N163**	Medical Record does not support code billed per the code definition	**259**	Frequency of service.

994	**UP TO 3 ROUTES ALLOWED FOR CHEMOTHERAPY ADMINISTRATION. IF MORE THAN 3 ROUTES REQUIRED, SUBMIT AS AN ADJUSTMENT WITH MEDICAL RECORDS DOUCUMENTING SERVICES**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**N29**	Missing documentation-orders-notes-summary-report-chart.	**297**	Medical notes/report.
994	**UP TO 3 ROUTES ALLOWED FOR CHEMOTHERAPY ADMINISTRATION. IF MORE THAN 3 ROUTES REQUIRED, SUBMIT AS AN ADJUSTMENT WITH MEDICAL RECORDS DOUCUMENTING SERVICES**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**N163**	Medical Record does not support code billed per the code definition	**297**	Medical notes/report.
995	**Service rendered by salaried FQHC physicians must be billed by the FQHC; payment cannot be made directly to the attending provider.**	**185**	The rendering provider is not eligible to perform the service billed. Note- Refer to the 835 Healthcare Policy Identificaiton Segment (loop 2110 Service Payment Information REF), if presentNote- Refer to the 835 Healthcare Policy Identificaiton 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.
996	**Payment has been adjusted to equal new purchase price. Medicaid has previously paid for this equipment code.**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**186**	Purchase and rental price of durable medical equipment.

997	**Full recoupment; Inpatient charges have been paid for some of these dates of service. Rebill for covered days only. Correct and resubmit as a new claim.**	**18**	Exact duplicate claim-service	**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.
999	**CPT chiropractic manipulative treatment codes not allowed on the same date of service as HCPCS manual manipulation of the spine.**	**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.
1001	**Recipient is entitled to Medicare but failed to apply. Service is not covered. Bill recipient.**	**177**	Patient has not met the required eligibility requirements.	**N196**	**Alert-** Patient eligible to apply for other coverage which may be primary	**197**	Effective coverage date(s).
1002	**Exceeds CAP-MR-DD personal emergency response monthly limitation.**	**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.
1003	**Date of service is more than 30 days prior to CAP effective date.**	**177**	Patient has not met the required eligibility requirements.	**N30**	Patient ineligible for this service.	**91**	Entity not eligible-not approved for dates of service.
1004	**Cap services recouped to pay inpatient stay charges. Cap service are not allowed during inpatient stay.**	**169**	Alternate benefit has been provided	**M2**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.

1004	**Cap services recouped to pay inpatient stay charges. Cap service are not allowed during inpatient stay.**	**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.
1004	**Cap services recouped to pay inpatient stay charges. Cap service are not allowed during inpatient stay.**	**169**	Alternate benefit has been provided	**N30**	Patient ineligible for this service	**258**	Days-units for procedure-revenue code.
1005	**Cap services denied when recipient is receiving inpatient services.**	**169**	Alternate benefit has been provided	**M2**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
1005	**Cap services denied when recipient is receiving inpatient services.**	**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.
1005	**Cap services denied when recipient is receiving inpatient services.**	**169**	Alternate benefit has been provided	**N30**	Patient ineligible for this service	**258**	Days-units for procedure-revenue code.
1006	**CAP limitation of 2016 hours per waiver year has been exceeded for crisis stabilization.**	**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.

1007	**Units have been changed to allow maximum on 31 units per month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
1007	**Units have been changed to allow maximum on 31 units per month.**	**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.
1007	**Units have been changed to allow maximum on 31 units per month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
1007	**Units have been changed to allow maximum on 31 units per month.**	**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.
1007	**Units have been changed to allow maximum on 31 units per month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**476**	Missing or invalid units of service
1007	**Units have been changed to allow maximum on 31 units per month.**	**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	**476**	Missing or invalid units of service
1008	**Sterilization guidelines not met. Invalid 'estimated date of confinement' on consent form.**	**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.
1008	**Sterilization guidelines not met. Invalid 'estimated date of confinement' on consent form.**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**492**	Other Procedure Date.

1009	**Procedure denied: Included in 52647 or 52648 already billed.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
1010	**W5142 not allowed on same day as J7300.**	**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.
1011	**J7300 not allowed same day as w5142.**	**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.
1012	**Units have been reduced to allow maximum of 60 therapeutic leave days for the calendar year.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N43**	Bed hold or leave days exceeded.	**498**	Maximum leave days exhausted
1012	**Units have been reduced to allow maximum of 60 therapeutic leave days for the calendar year.**	**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	**498**	Maximum leave days exhausted

1013	**Adult care home personal care service are not reimbursed when therapeutic leave has been paid for the same dates of service.**	**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.
1014	**Service denied or cut back. Exceeds 14 consecutive day limit.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
1014	**Service denied or cut back. Exceeds 14 consecutive day limit.**	**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.
1014	**Service denied or cut back. Exceeds 14 consecutive day limit.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
1014	**Service denied or cut back. Exceeds 14 consecutive day limit.**	**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.
1015	**DTP-HIB immunization previously paid for this date of service under codes 90720-90721.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1016	**DTAP immunization previously paid for this date of service under code 90700.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1017	**Initial observation has already been paid for this date of service.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

1018	**Observation discharge has already been paid for this date of service.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1019	**Evaluation and Management not allowed same day as NICU. NICU has already been paid for this date of service.**	**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.
1020	**Initial hour of prolonged services allowed once per date of service. Service has already been paid for this date.**	**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.
1020	**Initial hour of prolonged services allowed once per date of service. Service has already been paid for this date.**	**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
1021	**Critical care not allowed on same date of service as prolonged service. Prolonged service already paid for this date.**	**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.
1022	**Carolina access recipient's age is not valid for the approved emergency diagnosis.**	**9**	The diagnosis is inconsistent with the patients age.	**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.

1022	**Carolina access recipient's age is not valid for the approved emergency diagnosis.**	**9**	The diagnosis is inconsistent with the patients age.	**M76**	Missing-incomplete-invalid diagnosis or condition.	**255**	Diagnosis code.
1023	**Carolina access recipient's gender is not valid for the approved Emergency diagnosis.**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**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.
1023	**Carolina access recipient's gender is not valid for the approved Emergency diagnosis.**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M76**	Missing-incomplete-invalid diagnosis or condition.	**157**	Entitys Gender.
1023	**Carolina access recipient's gender is not valid for the approved Emergency diagnosis.**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M76**	Missing-incomplete-invalid diagnosis or condition.	**255**	Diagnosis code.
1024	**Prolonged service already paid for this date of service. No additional payment allowed for stand-by 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.

1025	**CAP-MR-DD prevocational services not allowed same day as supported employment services or institutional respite care.**	**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.
1026	**Reimbursement for related procedure is being recouped to pay primary procedure (52647 or 52648).**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
1027	**Reimbursement for therapeutic leave denied. Adult care home PCS has been paid for the same date (s) of service.**	**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.
1028	**CAP MR-DD supported employment service not allowed same day as prevocational services or institutional respite care.**	**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.

1029	**CAP MR-DD institutional respite not allowed on same day as related CAP services.**	**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.
1030	**Personal care not allowed on same day as CAP MR-DD supported living service.**	**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.
1031	**CAP MR-DD supported living services not allowed on same day as personal care.**	**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.

1032	**CAP MR-DD supported Living not allowed same day as related CAP services.**	**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.
1033	**Related CAP MR-DD services not on same day as supported living services.**	**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.
1034	**CAP MR-DD crisis stabilization not allowed on same date of service as institutional respite care.**	**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.
1035	**This EOB is for internal tracking of Health Check visits. To determine if claim paid or denied look in the screening section of your RA.**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement		**No Mapping Required**	**19**	Entity acknowledges receipt of claim-encounter.

1035	**This EOB is for internal tracking of Health Check visits. To determine if claim paid or denied look in the screening section of your RA.**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge.
1036	**Thank you for reporting vaccines. This vaccine is provided at no charge through the Vaccines For Children program. No payment allowed.**	**89**	Professional fees removed from charges.	**M41**	We do not pay for this as the patient has no legal obligation to pay for this.	**19**	Entity acknowledges receipt of claim-encounter.
1036	**Thank you for reporting vaccines. This vaccine is provided at no charge through the Vaccines For Children program. No payment allowed.**	**89**	Professional fees removed from charges.	**M41**	We do not pay for this as the patient has no legal obligation to pay for this.	**598**	Non-payable Professional Component Billed Amount.
1037	**Thanks for reporting vaccine to our database. Free modifier (F) is on claim; however vaccine is not available through VFC. Refile with 'P' modifier if you purchased vaccine.**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	**M41**	We do not pay for this as the patient has no legal obligation to pay for this.	**15**	One or more originally submitted procedure code have been modified.
1037	**Thanks for reporting vaccine to our database. Free modifier (F) is on claim; however vaccine is not available through VFC. Refile with 'P' modifier if you purchased vaccine.**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	**M41**	We do not pay for this as the patient has no legal obligation to pay for this.	**19**	Entity acknowledges receipt of claim-encounter.
1037	**Thanks for reporting vaccine to our database. Free modifier (F) is on claim; however vaccine is not available through VFC. Refile with 'P' modifier if you purchased vaccine.**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	**M41**	We do not pay for this as the patient has no legal obligation to pay for this.	**598**	Non-payable Professional Component Billed Amount.

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.
1039	**Regularly scheduled Health Check screening and interperiodic Health Check exam are not allowed on the 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.
1040	**Personal care services not allowed on the same date of service as Adult Care Home personal care service.**	**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.
1041	**Only one high risk intervention 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.
1042	**Only one Case Management allowed per day. Case management billed through another program has already been paid for this date of service.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

1043	**Units of service are not consistent with dates of service. One calendar day equals one unit for this HCPC code.**	**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.	**258**	Days-units for procedure-revenue code.
1043	**Units of service are not consistent with dates of service. One calendar day equals one unit for this HCPC code.**	**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.
1044	**Multiple billings of same or similar dme supply-equipment not allowed on the same date of service.**	**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.
1045	**PLEASE COMPLETE THE HYSTERECTOMY STATEMENT BY ADDING THE RECIPIENT'S COMPLETE ADDRESS**	**16**	Claim-service lacks information which is needed for adjudication	**MA37**	Missing-incomplete-invalid patients address	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1045	**PLEASE COMPLETE THE HYSTERECTOMY STATEMENT BY ADDING THE RECIPIENT'S COMPLETE ADDRESS**	**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.
1045	**PLEASE COMPLETE THE HYSTERECTOMY STATEMENT BY ADDING THE RECIPIENT'S COMPLETE ADDRESS**	**16**	Claim-service lacks information which is needed for adjudication	**MA37**	Missing-incomplete-invalid patients address	**126**	Entitys address.
1045	**PLEASE COMPLETE THE HYSTERECTOMY STATEMENT BY ADDING THE RECIPIENT'S COMPLETE ADDRESS**	**16**	Claim-service lacks information which is needed for adjudication	**N225**	Incomplete-invalid documentation-orders- notes-summary- report- chart.	**126**	Entitys address.

1045	**PLEASE COMPLETE THE HYSTERECTOMY STATEMENT BY ADDING THE RECIPIENT'S COMPLETE ADDRESS**	**16**	Claim-service lacks information which is needed for adjudication	**MA37**	Missing-incomplete-invalid patients address	**297**	Medical notes/report.
1045	**PLEASE COMPLETE THE HYSTERECTOMY STATEMENT BY ADDING THE RECIPIENT'S COMPLETE ADDRESS**	**16**	Claim-service lacks information which is needed for adjudication	**N225**	Incomplete-invalid documentation-orders- notes-summary- report- chart.	**297**	Medical notes/report.
1046	**PLEASE COMPLETE THE HYSTERECTOMY 'PRIOR TO MY SURGERY' STATEMENT BY ADDING THE COMPLETE DATE OF SURGERY**	**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.
1046	**PLEASE COMPLETE THE HYSTERECTOMY 'PRIOR TO MY SURGERY' STATEMENT BY ADDING THE COMPLETE DATE OF SURGERY**	**16**	Claim-service lacks information which is needed for adjudication	**N225**	Incomplete-invalid documentation-orders- notes-summary- report- chart.	**187**	Date(s) of service.
1046	**PLEASE COMPLETE THE HYSTERECTOMY 'PRIOR TO MY SURGERY' STATEMENT BY ADDING THE COMPLETE DATE OF SURGERY**	**16**	Claim-service lacks information which is needed for adjudication	**N225**	Incomplete-invalid documentation-orders- notes-summary- report- chart.	**297**	Medical notes/report.
1047	**THE WITNESS AND/OR RECIPIENT SIGNATURE HAS BEEN OMITTED ON THE HYSTERECTOMY STATEMENT. RESUBMIT A NEW COMPLETED "PRIOR TO MY SURGERY" STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**MA75**	Missing-incomplete-invalid patient or authorized representative signature.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

1047	**THE WITNESS AND/OR RECIPIENT SIGNATURE HAS BEEN OMITTED ON THE HYSTERECTOMY STATEMENT. RESUBMIT A NEW COMPLETED "PRIOR TO MY SURGERY" STATEMENT**	**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.
1047	**THE WITNESS AND/OR RECIPIENT SIGNATURE HAS BEEN OMITTED ON THE HYSTERECTOMY STATEMENT. RESUBMIT A NEW COMPLETED "PRIOR TO MY SURGERY" STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**MA75**	Missing-incomplete-invalid patient or authorized representative signature.	**297**	Medical notes/report.
1047	**THE WITNESS AND/OR RECIPIENT SIGNATURE HAS BEEN OMITTED ON THE HYSTERECTOMY STATEMENT. RESUBMIT A NEW COMPLETED "PRIOR TO MY SURGERY" STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N225**	Incomplete-invalid documentation-orders- notes-summary- report- chart.	**297**	Medical notes/report.
1048	**THE SIGNATURE/WITNESS DATE HAS BEEN OMITTED FROM THE HYSTERECTOMY STATEMENT. SUBMIT COMPLETED STATEMENT AND INITIAL THE DATE**	**16**	Claim-service lacks information which is needed for adjudication	**MA75**	Missing-incomplete-invalid patient or authorized representative signature	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1048	**THE SIGNATURE/WITNESS DATE HAS BEEN OMITTED FROM THE HYSTERECTOMY STATEMENT. SUBMIT COMPLETED STATEMENT AND INITIAL THE DATE**	**16**	Claim-service lacks information which is needed for adjudication	**MA75**	Missing-incomplete-invalid patient or authorized representative signature	**297**	Medical notes/report.

1048	**THE SIGNATURE/WITNESS DATE HAS BEEN OMITTED FROM THE HYSTERECTOMY STATEMENT. SUBMIT COMPLETED STATEMENT AND INITIAL THE DATE**	**16**	Claim-service lacks information which is needed for adjudication	**MA75**	Missing-incomplete-invalid patient or authorized representative signature	**492**	Other Procedure Date
1049	**THE DOS ON THE HYSTERECTOMY STATEMENT IS DIFFERENT THAN THE CLAIM. CORRECT AND RESUBMIT AS ADJUSTMENT WITH CLAIM AND STATEMENT ATTACHED**	**16**	Claim-service lacks information which is needed for adjudication	**M52**	Missing-incomplete-invalid from date(s) of service.	**187**	Date(s) of service.
1049	**THE DOS ON THE HYSTERECTOMY STATEMENT IS DIFFERENT THAN THE CLAIM. CORRECT AND RESUBMIT AS ADJUSTMENT WITH CLAIM AND STATEMENT ATTACHED**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart.	**187**	Date(s) of service.
1049	**THE DOS ON THE HYSTERECTOMY STATEMENT IS DIFFERENT THAN THE CLAIM. CORRECT AND RESUBMIT AS ADJUSTMENT WITH CLAIM AND STATEMENT ATTACHED**	**16**	Claim-service lacks information which is needed for adjudication	**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.

1049	**THE DOS ON THE HYSTERECTOMY STATEMENT IS DIFFERENT THAN THE CLAIM. CORRECT AND RESUBMIT AS ADJUSTMENT WITH CLAIM AND STATEMENT ATTACHED**	**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.
1049	**THE DOS ON THE HYSTERECTOMY STATEMENT IS DIFFERENT THAN THE CLAIM. CORRECT AND RESUBMIT AS ADJUSTMENT WITH CLAIM AND STATEMENT ATTACHED**	**16**	Claim-service lacks information which is needed for adjudication	**M52**	Missing-incomplete-invalid from date(s) of service.	**297**	Medical notes/report.
1049	**THE DOS ON THE HYSTERECTOMY STATEMENT IS DIFFERENT THAN THE CLAIM. CORRECT AND RESUBMIT AS ADJUSTMENT WITH CLAIM AND STATEMENT ATTACHED**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart.	**297**	Medical notes/report.
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.

1051	**At-Risk Case Management not allowed on same day as related Case Management services.**	**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.
1052	**Related Case Management service not allowed on same day as At-Risk Case Management.**	**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.
1053	**At-risk Case Management services are noncovered when recipient is receiving inpatient service.**	**169**	Alternate benefit has been provided	**M2**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
1053	**At-risk Case Management services are noncovered when recipient is receiving inpatient service.**	**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.
1053	**At-risk Case Management services are noncovered when recipient is receiving inpatient service.**	**169**	Alternate benefit has been provided	**N30**	Patient ineligible for this service	**258**	Days-units for procedure-revenue code.
1054	**At-risk Case Management service recouped. This service not allowed when recipient is receiving inpatient services.**	**169**	Alternate benefit has been provided	**M2**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.

1054	**At-risk Case Management service recouped. This service not allowed when recipient is receiving inpatient services.**	**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.
1054	**At-risk Case Management service recouped. This service not allowed when recipient is receiving inpatient services.**	**169**	Alternate benefit has been provided	**N30**	Patient ineligible for this service	**258**	Days-units for procedure-revenue code.
1055	**ER and hospital adm not allowed same DOS-same provider.**	**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.	**M2**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
1055	**ER and hospital adm not allowed same DOS-same provider.**	**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.
1055	**ER and hospital adm not allowed same DOS-same provider.**	**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.	**N30**	Patient ineligible for this service	**258**	Days-units for procedure-revenue code.

1056	**ER services recouped. ER services and hospital adm not allowed same DOS-same provider.**	**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.	**M2**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
1056	**ER services recouped. ER services and hospital adm not allowed same DOS-same provider.**	**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.
1056	**ER services recouped. ER services and hospital adm not allowed same DOS-same provider.**	**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.	**N30**	Patient ineligible for this service	**258**	Days-units for procedure-revenue code.
1057	**Valid revenue code must be billed with a valid HCPC code. HCPC code is missing or invalid or HCPC code has been billed with missing or invalid revenue code. Correct and resubmit.**	**125**	Submission-billing error(s)	**M20**	Missing-incomplete-invalid HCPCS. .	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

1057	**Valid revenue code must be billed with a valid HCPC code. HCPC code is missing or invalid or HCPC code has been billed with missing or invalid revenue code. Correct and resubmit.**	**125**	Submission-billing error(s)	**M50**	Missing-incomplete-invalid revenue code(s)	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1057	**Valid revenue code must be billed with a valid HCPC code. HCPC code is missing or invalid or HCPC code has been billed with missing or invalid revenue code. Correct and resubmit.**	**125**	Submission-billing error(s)	**M20**	Missing-incomplete-invalid HCPCS. .	**455**	Revenue code for services rendered.
1057	**Valid revenue code must be billed with a valid HCPC code. HCPC code is missing or invalid or HCPC code has been billed with missing or invalid revenue code. Correct and resubmit.**	**125**	Submission-billing error(s)	**M50**	Missing-incomplete-invalid revenue code(s)	**455**	Revenue code for services rendered.
1058	**The only well child exam billable through the Medicaid program is a Health Check Screen. For more information about billing Health Check, please call 1-800-688-6696.**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1059	**Ambulance claim form is no longer accepted. Please resubmit ambulance charges on the UB92 claim.**	**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.
1059	**Ambulance claim form is no longer accepted. Please resubmit ambulance charges on the UB92 claim.**	**125**	Submission-billing error(s)	**N34**	Incorrect claim form-format for this service.	**228**	Type of bill for UB claim

1060	**Admit hour-time of pickup is missing or invalid. Please correct and resubmit as a new claim.**	**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.
1061	**Only one date of service allowed per claim. Bill each ambulance trip on a separate claim.**	**125**	Submission-billing error(s)	**M53**	Missing-incomplete-invalid days or units of service.	**258**	Days-units for procedure-revenue code.
1063	**Therapeutic Abortion not done this DOS. Records state a post-abortion procedure was done. Correct your codes to post-abortion diagnosis-procedure and rebill.**	**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.
1063	**Therapeutic Abortion not done this DOS. Records state a post-abortion procedure was done. Correct your codes to post-abortion diagnosis-procedure and rebill.**	**125**	Submission-billing error(s)	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1063	**Therapeutic Abortion not done this DOS. Records state a post-abortion procedure was done. Correct your codes to post-abortion diagnosis-procedure and rebill.**	**125**	Submission-billing error(s)	**M64**	Missing-incomplete-invalid other diagnosis.	**187**	Date(s) of service.
1064	**Units are not consistent with procedure (s) billed. Verify your units, correct claim and resubmit.**	**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.	**258**	Days-units for procedure-revenue code.
1064	**Units are not consistent with procedure (s) billed. Verify your units, correct claim and resubmit.**	**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.

1065	**Cap personal care services not allowed on same date of service as Adult Care Home services.**	**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.
1066	**Cap in-home aide service not allowed on same date of service as Adult Care Home services.**	**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.
1067	**Home health aide service not allowed on same date of service as Adult Care Home services.**	**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.

1068	**Component(s) of urinalysis recouped. Urinalysis; with microscopy, which is the complete service, has been paid for this date of service, this provider.**	**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.
1069	**Components denied. Urinalysis with microscopy, which is a complete procedure has already been paid for this date of service, this provider.**	**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.
1070	**Urinalysis components billed for the same date of service must be combined under 81000. Please submit adjustment request to this effect for components already paid.**	**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**	We cannot pay for this when performed during the same session as a previously processed service for the patient	**454**	Procedure code for services rendered.
1070	**Urinalysis components billed for the same date of service must be combined under 81000. Please submit adjustment request to this effect for components already paid.**	**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.	**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	**454**	Procedure code for services rendered.

1071	**Urinalysis components billed for the same date of service must be combined under 81000. Please submit adjustment request to this effect for components already paid.**	**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**	We cannot pay for this when performed during the same session as a previously processed service for the patient	**454**	Procedure code for services rendered.
1071	**Urinalysis components billed for the same date of service must be combined under 81000. Please submit adjustment request to this effect for components already paid.**	**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.	**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	**454**	Procedure code for services rendered.
1072	**Renin Stimulation Panel has been paid for this date of service.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
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.
1074	**Components of Comprehensive Audiometry and Speech Recognition recouped. The complete service - Comprehensive Audiometry eval and Speech Recognition, has already been paid for this date of service, this provider.**	**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.

1075	**Components denied. Audiometry-Speech Recognition, which is a complete procedure, has already been paid for this date of service, this provider.**	**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.
1076	**Audiometry components billed for the same date of service must be combined as 92557. Please submit an adjustment request to this effect for component 92556 already 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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
1077	**Audiometry components billed for the same date of service must be combined as 92557. Please submit an adjustment request to this effect for component 92553 already 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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
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

1079	**Detail units of RC229 must equal the number of days calculated from the "from & to" dates in form locator 6 on approved UB. Correct your claim dates of service and resubmit.**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**M52**	Missing-incomplete-invalid from date(s) of service.	**258**	Days-units for procedure-revenue code.
1079	**Detail units of RC229 must equal the number of days calculated from the "from & to" dates in form locator 6 on approved UB. Correct your claim dates of service and resubmit.**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**M59**	Missing-incomplete-invalid to date(s) of service.	**258**	Days-units for procedure-revenue code.
1079	**Detail units of RC229 must equal the number of days calculated from the "from & to" dates in form locator 6 on approved UB. Correct your claim dates of service and resubmit.**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**M52**	Missing-incomplete-invalid from date(s) of service.	**476**	Missing or invalid units of service.
1079	**Detail units of RC229 must equal the number of days calculated from the "from & to" dates in form locator 6 on approved UB. Correct your claim dates of service and resubmit.**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**M59**	Missing-incomplete-invalid to date(s) of service.	**476**	Missing or invalid units of service.
1080	**Exceeds one per day limitation.**	**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.
1081	**CAP MR-DD adult care allowed once 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.
1082	**Exceeds one per day limitation.**	**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.

1083	**Only one spine deformity arthrodesis can be billed per operative episode per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1084	**Conflict in procedures billed. Anterior & Posterior procedures billed for same DOS. Review, Correct, Resubmit or file an adjustment with records.**	**16**	Claim-service lacks information which is needed for adjudication	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1084	**Conflict in procedures billed. Anterior & Posterior procedures billed for same DOS. Review, Correct, Resubmit or file an adjustment with records.**	**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.
1084	**Conflict in procedures billed. Anterior & Posterior procedures billed for same DOS. Review, Correct, Resubmit or file an adjustment with records.**	**16**	Claim-service lacks information which is needed for adjudication	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**294**	Supporting documentation
1084	**Conflict in procedures billed. Anterior & Posterior procedures billed for same DOS. Review, Correct, Resubmit or file an adjustment with records.**	**16**	Claim-service lacks information which is needed for adjudication	**N225**	Incomplete-invalid documentation-orders- notes-summary- report- chart.	**294**	Supporting documentation
1085	**Service denied. Records support segmental instrumentation previously paid for 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.
1086	**Review procedures. Billed-only one instrumentation proc allowed per day, correct and resubmit as a new claim.**	**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.

1087	**Insufficient documentation in records received to support therapeutic abortion to save life of mother. Resubmit with additional medical records as new day claim.**	**150**	Payer deems the information submitted does not support this level of service	**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.
1087	**Insufficient documentation in records received to support therapeutic abortion to save life of mother. Resubmit with additional medical records as new day claim.**	**150**	Payer deems the information submitted does not support this level of service	**N206**	The supporting documentation does not match the claim	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1087	**Insufficient documentation in records received to support therapeutic abortion to save life of mother. Resubmit with additional medical records as new day claim.**	**150**	Payer deems the information submitted does not support this level of service	**N29**	Missing documentation-orders-notes-summary-report-chart.	**294**	Supporting documentation
1087	**Insufficient documentation in records received to support therapeutic abortion to save life of mother. Resubmit with additional medical records as new day claim.**	**150**	Payer deems the information submitted does not support this level of service	**N206**	The supporting documentation does not match the claim	**294**	Supporting documentation
1088	**CAP MR-DD adult day health or developmental day care not allowed on same day as institutional respite.**	**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.

1089	**CAP MR-DD personal care service not allowed on same day as institutional respite.**	**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.
1090	**CAP MR-DD institutional respite not allowed on same day as personal care.**	**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.
1091	**RC636 must be billed with an approved HCPCS code for vitrocert.**	**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.
1091	**RC636 must be billed with an approved HCPCS code for vitrocert.**	**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.
1092	**This HCPCS code cannot be billed with RC636.**	**125**	Submission-billing error(s)	**M20**	Missing-incomplete-invalid HCPCS	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

1092	**This HCPCS code cannot be billed with RC636.**	**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.
1093	**Antepartum package 59425 has already been paid for this gestation period.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1094	**Stand-By service already paid for this date of service. No additional payment allowed for prolonged service on same DOS.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1095	**Observation service already paid for this date of service. No additional payment allowed for prolonged service on same DOS.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1096	**NICU already paid for this date of service. No additional payment allowed for prolonged service same DOS.**	**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.
1097	**Critical care has already paid for this date of service. No additional payment allowed for prolonged service same DOS.**	**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.

1098	**Antepartum package has already been paid for this gestation period.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1099	**NICU not allowed same day as Evaluation and Management code. E-M already paid for this 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.
1100	**DTP-HIB immunization has already been paid for this date of service under code Y2421.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1101	**DTAP immunization has already been paid for this date of service under Y2043.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1102	**Initial viewing of the X-ray by the ER physician is included in the ER visit and will not be reimbursed separately.**	**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.
1103	**Quantity outside min-max.**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**259**	Frequency of service.
1104	**Unacceptable price- unit. Check quantity and price.**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**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.

1104	**Unacceptable price- unit. Check quantity and price.**	**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.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1105	**Partial dispensing of unbreakable pack.**	**B5**	Coverage-program guidelines were not met or were exceeded.		**No Mapping Required**	**107**	Processed according to contract-plan provisions.
1106	**Exceeds limit of billings for antepartum package 4-6 visits, by different providers.**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**259**	Frequency of service.
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.
1108	**POS - Denial due to DUR Alert.**	**B5**	Coverage-program guidelines were not met or were exceeded.		**No Mapping Required**	**107**	Processed according to contract-plan provisions.
1109	**HCPCS for manipulation of spine Not allowed on same date of service as CPT chiropractic manipulative treatment codes.**	**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.
1110	**Enhanced maternity care coordination not allowed on same day as related service.**	**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.

1111	**Enhanced child service coordination not allowed on same day as related service.**	**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.
1112	**Related services not allowed on same date of service**	**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.
1113	**Enhanced maternity care coordination not allowed on same day as related service.**	**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.

1114	**Enhanced child service coordination not allowed on same day as related service.**	**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.
1115	**Related service not allowed on same day as enhanced child service coordination.**	**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.
1116	**Maternal outreach visits not allowed on the same day as enhanced maternity-child service coordination or maternity care coordination home visit.**	**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.

1117	**Maternity care home visit, enhanced maternity care coordination or enhanced child service coordination not allowed same day as maternal outreach visit already 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.	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
1118	**Maternal outreach worker visit already billed by and paid to DEHNR for this date of service.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1119	**Maternal outreach worker visit already billed by and paid to RHC-FQHC for this date of service.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1120	**Duplicate billing of base trip has previously been paid. If multiple trips, submit with documentation.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1121	**POS - Denied due to same week reversal.**	**B5**	Coverage-program guidelines were not met or were exceeded.		**No Mapping Required**	**107**	Processed according to contract-plan provisions.
1122	**Duplicate billing of a miles code has previously been paid. If multiple trips, with “out of base miles” on same day, submit an adjustment with documentation.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1123	**POS - metric decimal quantity.**	**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.

1124	**POS - DUR Alert override not found.**	**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.
1125	**Multiple diagnostic nasal Endoscopies are not allowed in the same day. Medicaid will consider the most complex (according to CPT description) for reimbursement.**	**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.
1126	**Diagnostic nasal endoscopy is not reimbursed separately from surgical nasal endoscopy billed for the same date of service.**	**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.
1127	**Control of nasal hemorrhage is not reimbursed separately when billed in addition to surgical nasal endoscopy with control of epistaxis.**	**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.

1128	**Surgery is included in nasal endoscopy with dacryocystorhinostomy.**	**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.
1129	**Resection of turbinate is included in surgical nasal endoscopy with concha bullosa resection billed for the same date of service.**	**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.
1130	**Nasal endoscopy with biopsy is not reimbursed separately from other surgical nasal endoscopy billed for the same date of service.**	**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.
1131	**Nasal endoscopy with sphenoidectomy is not reimbursed separately when performed on the same date of service as endoscopy with removal of tissue from sphenoid sinus.**	**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.

1132	**Craniotomy is not reimbursed separately when performed on the same date of service as nasal endoscopy in sphenoid region or endoscopy for repair of csf leak.**	**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.
1133	**Nasal endoscopy with removal of tissue from sphenoid sinus or spenoidectomy not reimbursed separately when billed in addition to endoscopy for other surgery in sphenoid region.**	**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.
1134	**This proc is included in the nasal endoscopy with medial and-or inferior orbital wall decompression or optcal nerve decompression billed by your facility for this date.**	**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.
1135	**This endoscopy surgery is not reimbursed separately when billed in addition to nasal endoscopy with medial and inferior wall decompression for the same date of service.**	**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.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**258**	Days-units for procedure-revenue code.

1136	**This surgical endoscopy procedure is not reimbursed as a separate procedure when billed in addition to endoscopy with optic nerve decompression for the same date of service.**	**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.
1137	**This procedure is not reimbursed separately when billed for the same date of service as more complex nasal endoscopy (i.e with repair CSF leak, orbital wall decompression).**	**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.
1138	**POS - PROCESSOR CONTROL NUMBER NOT FOUND.**	**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.
1139	**POS - VAN identification not on file.**	**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.

1140	**Component of x-ray (either technical or professional) denied because same procedure code has already been reimbursed as a complete procedure for this date of service.**	**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.
1141	**X-ray billed as 'complete' denied. Technical component of this procedure code has already been reimbursed for this date. Rebill for professional component only.**	**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.
1142	**X-ray billed as 'complete' denied. Professional component of this procedure code has already been reimbursed for this date. Rebill for technical component only.**	**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.

1142	**X-ray billed as 'complete' denied. Professional component of this procedure code has already been reimbursed for this date. Rebill for technical component only.**	**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.	**N195**	The technical component must be billed separately.	**454**	Procedure code for services rendered.
1143	**POS - production claim submitted in test.**	**B5**	Coverage-program guidelines were not met or were exceeded.		**No Mapping Required**	**107**	Processed according to contract-plan provisions.
1144	**POS - test claim submitted in production.**	**B5**	Coverage-program guidelines were not met or were exceeded.		**No Mapping Required**	**107**	Processed according to contract-plan provisions.
1145	**Multichannel lab test not allowed same date of service as lab panel.**	**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.
1146	**Multichannel lab test recouped to allow payment of lab panel.**	**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.

1147	**Cystourethroscopy with meatotomy not allowed on same day as Cysto. with resection. Resubmit as an adjustment with documentation supporting second cystourethroscopy on 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.	**M51**	Missing-incomplete-invalid procedure code(s) and-or dates.	**258**	Days-units for procedure-revenue code.
1147	**Cystourethroscopy with meatotomy not allowed on same day as Cysto. with resection. Resubmit as an adjustment with documentation supporting second cystourethroscopy on 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.
1148	**Cystourethroscopy with resection of ureterocele paid. Cysto with meatotomy recouped. Resubmit as an adjustment with documentation supporting second cystourethroscopy on same day.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
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.

1150	**Banding for this recipient was paid prior to the November 1, 1997 fee revisions; therefore, the maintenance visit was paid according the fees in existence at that time.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1151	**Probing of nasolacrimal duct with or without irrigation is included in a more comprehensive procedure already paid.**	**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.
1152	**Components denied. rebill using 92557 as complete procedure versus separate components 92553 and 92556.**	**125**	Submission-billing error(s)	**N56**	Procedure code billed is not correct-valid for the service 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.
1153	**Comprehensive procedure for probing nasolacrimal duct, which includes irrigation paid. Separate payment for component of comprehensive procedure recouped.**	**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.
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.
1155	**Only one lab panel code allowed per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

1156	**A valid hysterectomy statement is on file. Submit adjustment with records to support medical necessity, include: H&P/physical/operative records/path report & discharge summary**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-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.
1156	**A valid hysterectomy statement is on file. Submit adjustment with records to support medical necessity, include: H&P/physical/operative records/path report & discharge summary**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-incomplete-invalid documentation-orders-notes-summary-report-chart	**287**	Medical necessity for service.
1156	**A valid hysterectomy statement is on file. Submit adjustment with records to support medical necessity, include: H&P/physical/operative records/path report & discharge summary**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-incomplete-invalid documentation-orders-notes-summary-report-chart	**297**	Medical notes-report.
1157	**Delivery and-or postpartum care included in total ob package.**	**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.
1158	**Antepartum package recouped. Total ob package paid which includes antepartum 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.

1159	**Total ob package, which includes antepartum care, has already been paid for this gestation period.**	**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.
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.
1161	**Zantac or Tag met given IV or IM only allowed when billed on same day as chemotherapy.**	**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	**N195**	Procedure code incidental to primary procedure.	**465**	Principal Procedure Code for Service(s) Rendered.
1161	**Zantac or Tag met given IV or IM only allowed when billed on same day as chemotherapy.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1162	**Postpartum package recouped. OB package paid, which includes postpartum 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.

1163	**OB package, which includes postpartum care, has already been paid for this gestation period.**	**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.
1164	**TRANSPOSITION OF OVARIES INCLUDED IN ABDOMINAL HYSTERECTOMY. RESUBMIT AS AN ADJUSTMENT WITH RECORDS IF OVARIES WERE NOT RETURNED TO ORIGINAL PLACEMENT**	**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.	**M29**	Missing operative note-report.	**294**	Supporting documentation.
1164	**TRANSPOSITION OF OVARIES INCLUDED IN ABDOMINAL HYSTERECTOMY. RESUBMIT AS AN ADJUSTMENT WITH RECORDS IF OVARIES WERE NOT RETURNED TO ORIGINAL PLACEMENT**	**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.	**294**	Supporting documentation
1164	**TRANSPOSITION OF OVARIES INCLUDED IN ABDOMINAL HYSTERECTOMY. RESUBMIT AS AN ADJUSTMENT WITH RECORDS IF OVARIES WERE NOT RETURNED TO ORIGINAL PLACEMENT**	**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.	**M29**	Missing operative note-report.	**297**	Medical notes-report.

1164	**TRANSPOSITION OF OVARIES INCLUDED IN ABDOMINAL HYSTERECTOMY. RESUBMIT AS AN ADJUSTMENT WITH RECORDS IF OVARIES WERE NOT RETURNED TO ORIGINAL PLACEMENT**	**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.	**297**	Medical notes-report.
1165	**ABDOMINAL HYSTERECTOMY INCLUDES THE TRANSPOSITION OF OVARIES RESUBMIT AS AN ADJUSTMENT WITH RECORDS IF OVARIES WERE RETURNED TO ORIGINAL PLACEMENT**	**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.	**M29**	Missing operative note-report.	**294**	Supporting documentation.
1165	**ABDOMINAL HYSTERECTOMY INCLUDES THE TRANSPOSITION OF OVARIES RESUBMIT AS AN ADJUSTMENT WITH RECORDS IF OVARIES WERE RETURNED TO ORIGINAL PLACEMENT**	**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.	**294**	Supporting documentation.
1165	**ABDOMINAL HYSTERECTOMY INCLUDES THE TRANSPOSITION OF OVARIES RESUBMIT AS AN ADJUSTMENT WITH RECORDS IF OVARIES WERE RETURNED TO ORIGINAL PLACEMENT**	**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.	**M29**	Missing operative note-report.	**297**	Medical notes-report.

1165	**ABDOMINAL HYSTERECTOMY INCLUDES THE TRANSPOSITION OF OVARIES RESUBMIT AS AN ADJUSTMENT WITH RECORDS IF OVARIES WERE RETURNED TO ORIGINAL PLACEMENT**	**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.	**297**	Medical notes-report.
1166	**Superficial Hyperthermia recouped. Medicaid does not make separate payment for procedures that are components of a more comprehensive service for the same date of service.**	**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.
1167	**DME allowed once in four years. If prior approval was obtained for this piece of equipment for dates of service prior to Nov 1, 1996, please resubmit as an Adjustment.**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**187**	Date(s) of service.
1167	**DME allowed once in four years. If prior approval was obtained for this piece of equipment for dates of service prior to Nov 1, 1996, please resubmit as an Adjustment.**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**259**	Frequency of service.
1168	**Arthrodesis, hip joint included in fusion of hip joint.**	**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.

1169	**Superficial Hyperthermia denied. Medicaid does not make separate payment for procedures that are components of a more comprehensive 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.	**454**	Procedure code for services rendered.
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.
1171	**Diagnosis requires supporting documentation. Resubmit adjustment with medical records**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes-summary-report-chart.	**297**	Medical notes-report.
1171	**Diagnosis requires supporting documentation. Resubmit adjustment with medical records**	**16**	Claim-service lacks information which is needed for adjudication	**N163**	Medical Record does not support code billed per the code definition.	**297**	Medical notes-report.

1172	**Tenotomy for multiple tendons can not be billed same date of service as single tendons.**	**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.
1173	**Superficial hyperthermia not allowed on same date of service as chemotherapy administration**	**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.
1174	**Thanks for reporting vaccine to our database. This vaccine is available at no charge through the Vaccines For Children program and therefore is not reimbursable**	**89**	Professional fees removed from charges.	**M41**	We do not pay for this as the patient has no legal obligation to pay for this.	**19**	Entity acknowledges receipt of claim-encounter.
1174	**Thanks for reporting vaccine to our database. This vaccine is available at no charge through the Vaccines For Children program and therefore is not reimbursable**	**89**	Professional fees removed from charges.	**M41**	We do not pay for this as the patient has no legal obligation to pay for this.	**598**	Non-payable Professional Component Billed Amount.
1175	**Dialysis facility: this revenue code must be billed with the appropriate 5-digit CPT code. correct denied detail and refile as a new day 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.

1175	**Dialysis facility: this revenue code must be billed with the appropriate 5-digit CPT code. correct denied detail and refile as a new day claim.**	**125**	Submission-billing error(s)	**N50**	Missing-incomplete-invalid discharge information.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1175	**Dialysis facility: this revenue code must be billed with the appropriate 5-digit CPT code. correct denied detail and refile as a new day claim**	**125**	Submission-billing error(s)	**M51**	Missing-incomplete-invalid procedure code(s).	**455**	Revenue code for services rendered.
1175	**Dialysis facility: this revenue code must be billed with the appropriate 5-digit CPT code. correct denied detail and refile as a new day claim.**	**125**	Submission-billing error(s)	**N50**	Missing-incomplete-invalid discharge information.	**455**	Revenue code for services rendered.
1176	**This drug is included in monthly dialysis rate.**	**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.
1177	**Dialysis facility: This revenue code must be billed with a valid 5 digit HCPCS drug code. Correct denied detail and refile as a new day 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.
1177	**Dialysis facility: This revenue code must be billed with a valid 5 digit HCPCS drug code. Correct denied detail and refile as a new day claim.**	**125**	Submission-billing error(s)	**N50**	Missing-incomplete-invalid discharge information.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

1177	**Dialysis facility: This revenue code must be billed with a valid 5 digit HCPCS drug code. Correct denied detail and refile as a new day claim.**	**125**	Submission-billing error(s)	**M51**	Missing-incomplete-invalid procedure code(s).	**455**	Revenue code for services rendered.
1177	**Dialysis facility: This revenue code must be billed with a valid 5 digit HCPCS drug code. Correct denied detail and refile as a new day claim.**	**125**	Submission-billing error(s)	**N50**	Missing-incomplete-invalid discharge information.	**455**	Revenue code for services rendered.
1178	**Rebill first date of on-going dialysis TX with occurrence code 51 on the approved UB before DOS 06-01-03, occurrence code 11 on and after 06-01-03. CMS 1500: Add date in block 15.**	**125**	Submission-billing error(s)	**M45**	Missing-incomplete-invalid occurrence code(s).	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1178	**Rebill first date of on-going dialysis TX with occurrence code 51 on the approved UB before DOS 06-01-03, occurrence code 11 on and after 06-01-03. CMS 1500: Add date in block 15.**	**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.
1178	**Rebill first date of on-going dialysis TX with occurrence code 51 on the approved UB before DOS 06-01-03, occurrence code 11 on and after 06-01-03. CMS 1500: Add date in block 15.**	**125**	Submission-billing error(s)	**M45**	Missing-incomplete-invalid occurrence code(s).	**213**	Date of first routine dialysis.
1178	**Rebill first date of on-going dialysis TX with occurrence code 51 on the approved UB before DOS 06-01-03, occurrence code 11 on and after 06-01-03. CMS 1500: Add date in block 15.**	**125**	Submission-billing error(s)	**MA31**	Missing-incomplete-invalid beginning and ending dates of the period billed.	**213**	Date of first routine dialysis.

1178	**Rebill first date of on-going dialysis TX with occurrence code 51 on the approved UB before DOS 06-01-03, occurrence code 11 on and after 06-01-03. CMS 1500: Add date in block 15.**	**125**	Submission-billing error(s)	**M45**	Missing-incomplete-invalid occurrence code(s).	**720**	NUBC Occurrence Code Date(s)
1178	**Rebill first date of on-going dialysis TX with occurrence code 51 on the approved UB before DOS 06-01-03, occurrence code 11 on and after 06-01-03. CMS 1500: Add date in block 15.**	**125**	Submission-billing error(s)	**MA31**	Missing-incomplete-invalid beginning and ending dates of the period billed.	**720**	NUBC Occurrence Code Date(s)
1179	**57505 Recouped, Endocervical Curettage included in CPT codes 57454 and 57456.**	**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.
1180	**57505-endocervical curettage included in previous paid code, 57454.**	**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.
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 Identificaiton 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.
1184	**Insertion of vitrocert is covered only for the diagnosis of cytomegalovirus retinitis (CMV).**	**11**	The diagnosis is inconsistent with the procedure.	**M76**	Missing-incomplete-invalid diagnosis or condition.	**255**	Diagnosis code.
1184	**Insertion of vitrocert is covered only for the diagnosis of cytomegalovirus retinitis (CMV).**	**11**	The diagnosis is inconsistent with the procedure.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**255**	Diagnosis code.
1185	**Only one billing of chiropractic manipulative treatment allowed - 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.
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.

1187	**Injectable drug adm code not allowed same DOS as chemotherapy.**	**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
1188	**Chemotherapy not allowed same date of service as injectable drug administration code. Injectable drug administration fee recouped.**	**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
1189	**Medicaid does not make separate payment for professional or technical component performed on the same DOS as the complete 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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.

1190	**Complete proc performed on the same DOS as the professional of technical component not allowed. Component recouped.**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
1191	**Arthrotomy, knee, with synovial biopsy only included in joint exploration, biopsy or removal.**	**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.
1192	**Medicaid does not make separate payment for professional or technical component performed on the same date of service as the complete 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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
1193	**Complete procedure performed on the same date of service as the professional or technical component not allowed.**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.

1194	**Arthrotomy with excision of semilunar cartilage included in knee excision semilunar cartilage.**	**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.
1195	**Medicaid does not make separate payment for professional or technical component performed on the same date of service as the complete 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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
1196	**Complete procedure performed on the same date of service as the professional or technical component not allowed.**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
1197	**Physician service and visual aids cannot be processed on the same claim. Resubmit physician service on a separate CMS 1500 claim.**	**125**	Submission-billing error(s)	**N61**	Rebill services on separate claims.	**276**	UB04-HCFA-1450-1500 claim form.
1197	**Physician service and visual aids cannot be processed on the same claim. Resubmit physician service on a separate CMS 1500 claim.**	**125**	Submission-billing error(s)	**N61**	Rebill services on separate claims.	**481**	Claim-submission format is invalid.

1198	**Service billed multiple times. If on this claim, combine units on single detail & submit new claim. If paid on previous claim, combine units & file ADJ.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**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.	**259**	Frequency of service.
1198	**Service billed multiple times. If on this claim, combine units on single detail & submit new claim. If paid on previous claim, combine units & file ADJ.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N130**	**Alert-** Consult plan benefit documents for information about restrictions for this service	**259**	Frequency of service.
1198	**Service billed multiple times. If on this claim, combine units on single detail & submit new claim. If paid on previous claim, combine units & file ADJ.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**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.	**476**	Missing or invalid units of service
1198	**Service billed multiple times. If on this claim, combine units on single detail & submit new claim. If paid on previous claim, combine units & file ADJ.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N130**	**Alert-** Consult plan benefit documents for information about restrictions for this service	**476**	Missing or invalid units of service
1199	**Related lab tests included in fee for panel, same date of 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.

1200	**Panel includes fees for related lab tests, same date of 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.
1201	**Patient is enrolled in a HMO Plan. Delivery charges have been made to the HMO. Facilities may bill fee for service for care rendered on out-of-plan dates of service.**	**24**	Charges are covered under a capitation agreement-managed care plan		**No Mapping Required**	**96**	No agreement with entity.
1201	**Patient is enrolled in a HMO Plan. Delivery charges have been made to the HMO. Facilities may bill fee for service for care rendered on out-of-plan dates of service.**	**24**	Charges are covered under a capitation agreement-managed care plan		**No Mapping Required**	**187**	Date(s) of service.
1201	**Patient is enrolled in a HMO Plan. Delivery charges have been made to the HMO. Facilities may bill fee for service for care rendered on out-of-plan dates of service.**	**24**	Charges are covered under a capitation agreement-managed care plan		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge.
1202	**Patient is enrolled in a HMO plan. Delivery charges have been made to the HMO. Facilities may bill fee for service for care rendered on out-of-plan dates of service**	**24**	Charges are covered under a capitation agreement-managed care plan		**No Mapping Required**	**187**	Date(s) of service.

1202	**Patient is enrolled in a HMO plan. Delivery charges have been made to the HMO. Facilities may bill fee for service for care rendered on out-of-plan dates of service**	**24**	Charges are covered under a capitation agreement-managed care plan		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge.
1203	**Iv sedation and general anesthesia not allowed on same dates of service**	**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.
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
1205	**Arthrotomy with synovectomy knee included in arthrotomy knee anterior and posterior.**	**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.

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
1207	**RC651 and RC652 must be billed with value code 61 with corresponding MSA code.**	**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.
1207	**RC651 and RC652 must be billed with value code 61 with corresponding MSA code.**	**125**	Submission-billing error(s)	**M49**	Missing-incomplete-invalid value code(s) or amount(s).	**725**	NUBC Value Code(s)
1208	**Invalid MSA code. Please correct and resubmit as a new day 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.
1209	**Purchase of supplies related to suction equipment not allowed during the same month equipment is rented.**	**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.

1210	**Service recouped. Supplies related to suction equipment can not be billed within the same calendar month.**	**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.	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**259**	Frequency of service.
1210	**Service recouped. Supplies related to suction equipment can not be billed within the same calendar month.**	**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	**259**	Frequency of service.
1210	**Service recouped. Supplies**	**97**	The benefit for this service is	**N357**	Time frame requirements between this service-procedure-	**453**	Procedure Code Modifier(s) for

1211	**Topical application of fluoride not allowed to bill on the same date of service as prophylaxis application (0-20)**	**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.
1212	**Tenotomy, single tendon can not be billed same date of service as multiple tendons.**	**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.
1213	**Prophylaxis application of flouride not allowed to bill on the same date of service as topical application (0-20).**	**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.

1214	**Hamstring single and multiple tendon lengthening not allowed same date of service**	**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.
1215	**Transplant, hamstring tendon to patella; single tendon not allowed on same day as multiple tendons.**	**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.
1216	**Reconstruction of dislocating patella not allowed same as extensor realignment with patellectomy and-or revision removal of knee cap.**	**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.

1217	**Extensor realignment not allowed same day as reconstruction for recurrent dislocating patella.**	**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.
1218	**Only one catheter or reservoir-pump implantation allowed per day, same or different provider.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1219	**Arthroplasty, femoral condyles not allowed with repair of knee joint.**	**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.
1220	**Revision of total knee arthroplasty, with or without allograft not allowed same day as one component.**	**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.

1221	**Tenotomy, percutaneous, Achilles tendon not allowed same day as 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.	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
1222	**An electronic analysis of cardioverter-defibrillator with programming procedure already paid for this date of service**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1223	**An electronic analysis of cardioverter-defibrillator procedure already paid for this date of service**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
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).

1225	**Arthrotomy, posterior capsular release, ankle not allowed on the same day as lengthening or shortening of tendon.**	**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.
1226	**Biopsy, soft tissue of leg or ankle area not allowed same day as superficial.**	**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.
1227	**Excision, tumor, leg or ankle area not allowed same day as excision benign tumor deep subfacial.**	**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.

1228	**Repair, flexor tendon, leg, primary, without graft, not allowed same day as secondary with or without graft.**	**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.
1229	**Repair, extensor tendon, legs; primary without graft not allowed same day as secondary with or without graft.**	**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.
1230	**Tenolysis, flexor or extension tendon not allowed same day as multiple.**	**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.

1231	**Dental exam not allowed same date of service as initial hospital care.**	**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.
1232	**Non-ER service billed for CA recipient with incorrect authorization # on CMS 1500. If Mon-Fri between 5PM and 8AM or Sat-Sun contact PCP for Authorization**	**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.
1232	**Non-ER service billed for CA recipient with incorrect authorization # on CMS 1500. If Mon-Fri between 5PM and 8AM or Sat-Sun contact PCP for Authorization**	**125**	Submission-billing error(s)	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**276**	UB04-HCFA-1450-1500 claim form
1233	**Non-ER service billed for CA recipient without auth if mon-fri between 5PM and 8AM or Sat-Sun contact PCP for auth or submit claim to the managed care section of DMA for retro-review.**	**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.
1233	**Non-ER service billed for CA recipient without auth if mon-fri between 5PM and 8AM or Sat-Sun contact PCP for auth or submit claim to the managed care section of DMA for retro-review.**	**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.	**48**	Referral-authorization.

1233	**Non-ER service billed for CA recipient without auth if mon-fri between 5PM and 8AM or Sat-Sun contact PCP for auth or submit claim to the managed care section of DMA for retro-review.**	**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.	**515**	Managed Care review
1234	**Single tendon lengthening or shortening not allowed same day as multiple.**	**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.
1235	**Superficial and deep transfer or transplant of single tendon not allowed on the same date of service.**	**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.
1236	**Allow one application of flouride within six calendar months**	**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.
1236	**Allow one application of flouride within six calendar months**	**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.
1236	**Allow one application of flouride within six calendar months**	**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

1236	**Allow one application of flouride within six calendar months**	**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
1237	**Repair, secondary disrupted ligament, ankle not allowed same day as primary and both collateral ligaments.**	**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.
1238	**Arthroplasty, ankle, revision not allowed same day as repair of ankle.**	**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.
1239	**Paring or cutting of benign hyperkeratotic lesions or lesion allowed only once 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.
1240	**Arrest, epiphyseal, any method not allowed same day as repair lower leg epiphyses.**	**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.

1241	**Incision and drainage below fascia not allowed same day as drainage of foot.**	**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.
1242	**Tenotomy, percutaneous, toe, single tendon not allowed same day as multiple.**	**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.
1243	**Excision, tumor, foot not allowed same day as benign tumor deep subfascial intramuscular.**	**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.

1244	**Fasciectomy, plantar facia; partial not allowed same day as removal of foot fascia.**	**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.
1245	**Single or two segment kyphectomy not allowed same date of service as three or more segment kyphectomy.**	**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.
1246	**Three or more segment kyphectomy not allowed same date of service as single or two segment kyphectomy.**	**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.

1247	**Ostectomy, complete excision not allowed same day as partial removal metatarsal.**	**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.
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.
1249	**Tenolysis, extensor, foot; single tendon not allowed same day as multiple.**	**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.

1250	**Osteotomy, tarsal bones, other than calcaneous or talus not allowed same day as autograft.**	**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.
1251	**Osteotomy, with or without lengthening, metatarsal not allowed same day as first metatarsal with autograft of multiple.**	**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.
1252	**Injectable drug administration not allowed same date of service as office visit.**	**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.

1253	**Office visit not allowed on same DOS as inj drug adm. Inj drug adm fee recouped.**	**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.
1254	**Transesophageal echocardiography for congenital cardiac anomalies complete procedure includes components for probe placement and-or image acquisition.**	**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.
1255	**Components of transesophageal echocardiography are included in the complete procedure already paid for this date of service.**	**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.

1256	**Physician interpretation of cervical or vaginal cytopathology not allowed same DOS as related complete proc.**	**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.
1257	**Service recouped. Complete cytopathology procedure not allowed same DOS as physician's interpretation.**	**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.
1258	**Osteotomy, with or without lengthening, each other than first metarsal not allowed same day as multiple.**	**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.
1259	**Reoperation, more than 1 month after original operation must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.

1259	**Reoperation, more than 1 month after original operation must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1260	**Medicaid does not make separate payment for professional or technical component performed on the same date of service as complete service.**	**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.
1261	**Complete procedure performed on the same date of service as professional or technical component not allowed. component recouped.**	**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.
1262	**Related bypass procedures not allowed to bill 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.

1263	**Medicaid does not make separate payment for professional or technical component performed on the same date of service as the complete 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.
1264	**Complete procedure performed on the same date of service as the professional or technical component not allowed.**	**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.
1265	**Chromatography, single analytes not allowed same DOS as multiple analytes.**	**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.

1266	**Medicaid does not make separate payment for professional or technical component performed on the same date of service as the complete 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.
1267	**Complete procedure performed on the same date of service as the professional of technical component not allowed, component recouped.**	**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.
1268	**Very long chain fatty acids not allowed same DOS as fatty acids, No Mapping Requiredsterified.**	**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.

1269	**Medicaid does not make separate payment for professional or technical component performed on the same date of service as the complete 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.
1270	**Complete procedure performed on the same date of service as the professional or technical component not allowed. component recouped.**	**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.
1272	**Medicaid does not make separate payment for professional or technical component performed on the same date of service as the complete 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.

1273	**Complete procedure performed on the same date of service as the professional or technical component not allowed. component recouped.**	**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.
1274	**For recipients with Medicare, Medicaid will only reimburse for this DME item if Medicare has allowed or paid**	**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.
1275	**Patient monthly liability not on eligibility file. contact county dss.**	**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.
1276	**Medicaid does not make separate payment for professional or technical component performed on the same date of service as the complete 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.

1277	**Complete procedure performed on the same date of service as the professional or technical component not allowed, component recouped.**	**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.	**259**	Frequency of service.
1278	**Combined units of RC679, RC599 or RC183 must equal number of days calculated from the 'from' & 'to' dates in form locator 6 on approved UB. Correct claim dates & resubmit**	**125**	Submission-billing error(s)	**M52**	Missing-incomplete-invalid from date(s) of service.	**12**	One or more originally submitted procedure codes have been combined.
1278	**Combined units of RC679, RC599 or RC183 must equal number of days calculated from the 'from' & 'to' dates in form locator 6 on approved UB. Correct claim dates & resubmit**	**125**	Submission-billing error(s)	**M53**	Missing-incomplete-invalid days or units of service.	**12**	One or more originally submitted procedure codes have been combined.
1278	**Combined units of RC679, RC599 or RC183 must equal number of days calculated from the 'from' & 'to' dates in form locator 6 on approved UB. Correct claim dates & resubmit**	**125**	Submission-billing error(s)	**M59**	Missing-incomplete-invalid to date(s) of service.	**12**	One or more originally submitted procedure codes have been combined.
1278	**Combined units of RC679, RC599 or RC183 must equal number of days calculated from the 'from' & 'to' dates in form locator 6 on approved UB. Correct claim dates & resubmit**	**125**	Submission-billing error(s)	**M52**	Missing-incomplete-invalid from date(s) of service.	**258**	Days-units for procedure-revenue code.

1278	**Combined units of RC679, RC599 or RC183 must equal number of days calculated from the 'from' & 'to' dates in form locator 6 on approved UB. Correct claim dates & resubmit**	**125**	Submission-billing error(s)	**M53**	Missing-incomplete-invalid days or units of service.	**258**	Days-units for procedure-revenue code.
1278	**Combined units of RC679, RC599 or RC183 must equal number of days calculated from the 'from' & 'to' dates in form locator 6 on approved UB. Correct claim dates & resubmit**	**125**	Submission-billing error(s)	**M59**	Missing-incomplete-invalid to date(s) of service.	**258**	Days-units for procedure-revenue code.
1279	**Medicaid does not make separate payment for professional or technical component performed on the same date of service as the complete 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.
1280	**Complete procedure performed on the same date of service as the professional or technical component not allowed. component recouped.**	**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.

1281	**Helicobacter pylori breath test analysis not allowed to bill on same DOS as drug administration and sample collection.**	**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.
1282	**Medicaid does not make separate payment for professional or technical component performed on the same date of service as the complete 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.
1283	**Completed procedure performed on the same date of service as the professional or technical component not allowed. Component recouped**	**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.
1284	**Outpatient drug and alcohol rehab services are only contracted through the area mental health program.**	**52**	The referring-prescribing-rendering provider is not eligible to refer-prescribe-order-perform the service billed.	**N95**	This provider type - provider specialty may not bill this service.	**84**	Service not authorized.
1284	**Outpatient drug and alcohol rehab services are only contracted through the area mental health program.**	**52**	The referring-prescribing-rendering provider is not eligible to refer-prescribe-order-perform the service billed.	**N538**	A facility is responsible for payment to outside providers who furnish these services-supplies-drugs to its patients-residents.	**84**	Service not authorized.

1285	**Components of basic metabolic panel recouped to allow reimbursement of panel 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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
1286	**This lab test is included in fee for metabolic panel.**	**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.
1287	**Component of electrolyte panel recouped to allow reimbursement of 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.	**54**	Duplicate of a previously processed claim-line.
1288	**This lab test is included in fee for electrolyte panel.**	**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.

1289	**Components of comprehensive metabolic panel recouped to allow reimbursement for 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.	**54**	Duplicate of a previously processed claim-line.
1290	**This lab test is included in the fee for comprehensive metabolic panel.**	**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.
1291	**Chemiluminescent assay and molecular diagnostics not allowed same date of service as hiv-1 quantification.**	**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.
1292	**Related Lipo protein procedures not allowed same DOS as primary 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.

1293	**Service recouped. HIV quantification includes amplified probe technique.**	**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.
1294	**Amplified probe technique included in HIV quantification.**	**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.
1295	**Related molecular diagnostics procedures not allowed same DOS as primary 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.
1296	**Case management recouped to allow payment for Case Management to a CAP provider within the same calendar month.**	**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.	**259**	Frequency of service.

1297	**Related patient nucleic acid procedures not allowed same DOS as primary procedures.**	**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.
1298	**Destruction of benign or premalignant lesions numbering one to fourteen not allowed same date of service as destruction of fifteen or more lesions.**	**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.
1299	**Service recouped. destruction of fifteen or more lesions not allowed same.**	**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.

1300	**Immunization update and Health Check screen not allowed same day by same or different health department.**	**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.
1301	**Immunization update and Health Check not allowed on same date of service by same provider before 3-1-95.**	**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.
1302	**Incision and drainage of pilonidal cyst can not be billed same day as complicated incision and drainage of pilonidal cyst.**	**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.

1303	**Prostate specific antigen (psa) free not allowed same DOS as total.**	**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.
1304	**Debridement of infected skin up to 10% of body surface not allowed same day as each additional 10%.**	**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.
1305	**Sugars; single qualitative cannot be billed same DOS as multiple qualitative.**	**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.

1306	**Injection, intralesional; up to and including seven lesions can not be billed same day as more than seven lesions.**	**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.
1307	**Provider number invalid for CSHS code(s) billed.**	**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.
1307	**Provider number invalid for CSHS code(s) billed.**	**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.
1308	**Debridement of nail(s) by any method(s): one to five can not be billed same day as more than six.**	**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.
1309	**Sugars, single quanitative cannot be billed same DOS as multiple quanitative.**	**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.

1310	**Only one simple repair code for each group of anatomic sites is allowed per date of service**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1310	**Only one simple repair code for each group of anatomic sites is allowed per date of service**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
1311	**Simple pulmonary stress testing not allowed same DOS as complex testing.**	**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.
1312	**Treatment of simple closure not allowed same day as with packing.**	**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.
1313	**Date is missing. Please correct and submit as a new claim.**	**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.
1314	**Only one intermediate repair code allowed per DOS.**	**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.

1314	**Only one intermediate repair code allowed per DOS.**	**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
1315	**Selective catheter placement, add'l 2nd, 3rd and beyond order must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1315	**Selective catheter placement, add'l 2nd, 3rd and beyond order must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1316	**Repair, complex, trunk; 1.1 cm to 2.5 cm not allowed same day as 2.6 to 7.5 cm.**	**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.
1317	**Multiple canula declotting procedures not allowed on same date.**	**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.

1318	**Repair complex scalp arms and or legs; 1.1cm to 2.5 cm not allowed same day as 2.6 to 7.5cm.**	**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.
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
1320	**Complex repair 1.1 cm to 2.5 cm not allowed same date of service as related 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.
1321	**Complex repair of over 2.6 cm to 7.5 cm not allowed same date of service as related 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.

1322	**OB package paid. Previously paid labs, office visits, consultations or other services included in ob package will be recouped.**	**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.
1323	**Transcatheter placement of an intravascular stent, each additional vessel must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1323	**Transcatheter placement of an intravascular stent, each additional vessel must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1324	**Claims must be processed through DEHNR. Refer to your manual for processing instructions.**	**109**	Claim not covered by this payer-contractor. You must send the claim to the correct payer-contractor.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**116**	Claim submitted to incorrect payer.
1325	**Punch graft for hair transplant not allowed same day of service as grafts for hair transplant of more than fifteen punch grafts.**	**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.

1326	**Punch graft for hair transplant not allowed same day of service as grafts for hair transplant from 1-15 punch grafts.**	**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.
1327	**Salabrasion not allowed same day of service if less than 20sq. cm.**	**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.
1328	**Salabrasion not allowed same day of service if over 20sq cm.**	**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.

1329	**Treatment of burn wound up to one percent of body area not allowed same day of service as related 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.
1330	**Treatment of burn wound up to nine percent of body area not allowed same day of service as related 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.
1331	**Complex repair 1.0 cm or less not allowed same date of service as related 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.

1332	**Complex repair 1.1 cm to 2.5 cm not allowed same date of service as related procedures.**	**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.
1333	**Complex repair 2.6 cm to 7.5 cm not allowed same date of service as related 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.
1334	**Encounter. provider specialty number missing or invalid. refer to appendix A. Choose the appropriate specialty for the provider performing the service 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.	**132**	Entitys Medicaid provider id. Note- This code requires use of an Entity Code.
1334	**Encounter. provider specialty number missing or invalid. refer to appendix A. Choose the appropriate specialty for the provider performing the service 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.	**144**	Entitys specialty license number.

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.
1336	**CAP respite not allowed same date as Adult Care Homes, PCS or therapeutic leave.**	**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.
1337	**Adult Care Homes PCS and Therapeutic Leave not allowed same date as CAP respite.**	**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.
1338	**Enterectomy, each additional resection must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1338	**Enterectomy, each additional resection must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.

1339	**Client behavior intervention services not allowed within the same month as assertive community treatment.**	**169**	Alternate benefit has been provided	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
1339	**Client behavior intervention services not allowed within the same month as assertive community treatment.**	**169**	Alternate benefit has been provided	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**258**	Days-units for procedure-revenue 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.
1341	**Periodic services and-or high risk intervention services not allowed within the same calendar month as assertive community treatment team services.**	**169**	Alternate benefit has been provided	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
1341	**Periodic services and-or high risk intervention services not allowed within the same calendar month as assertive community treatment team**	**169**	Alternate benefit has been provided	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**258**	Days-units for procedure-revenue code.
					between this service-procedure-		

1343	**Residential high risk intervention not allowed the same day as professional treatment services in crisis facilities.**	**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.
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
1345	**Unit limitation exceeded for diagnosis billed.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**255**	Diagnosis code.
1345	**Unit limitation exceeded for diagnosis billed.**	**119**	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.
1346	**Excision, each additional lesion must bill with primary proc**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1346	**Excision, each additional lesion must bill with primary proc**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1347	**Hysterectomy after cesarean delivery must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.

1347	**Hysterectomy after cesarean delivery must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1348	**Capsulotomy, midfoot not allowed with tendon lengthening.**	**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.
1349	**Transection or ligation procedures must be billed with primary.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1349	**Transection or ligation procedures must be billed with primary.**	**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.	**465**	Principal Procedure Code for Service(s) 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.**	**16**	Claim-service lacks information	**MA81**	Missing-incomplete-invalid	**117**	Claim requires signature-on-
							Entities original signature. Note-

1352	**Laminotomy, each additional interspace must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1352	**Laminotomy, each additional interspace must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1353	**Laminotomy, each additional segment must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1353	**Laminotomy, each additional segment must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1354	**Transpedicular, each additional segment must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1354	**Transpedicular, each additional segment must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.

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.
1356	**Incision and drainage of abscess can not be billed same day as complicated or multiple incision and drainage of abscess.**	**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.
1357	**Diskectomy, thoracic, single interspace must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.

1357	**Diskectomy, thoracic, single interspace must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
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.
1359	**Vertebral corpectomy, cervical, each additional segment must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1359	**Vertebral corpectomy, cervical, each additional segment must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1360	**92551 and-or 92552 is not allowed on the same date of service as W8014.**	**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.

1361	**Destruction of lesions by any method second through fourteen not allowed same date of service as related 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.
1362	**Destruction of lesions by any method fifteen or more not allowed same date of service as related 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.
1363	**Vertebral corpectomy, thoracic, each additional segment.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1363	**Vertebral corpectomy, thoracic, each additional segment.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.

1364	**Destruction of warts, molluscum contagiosum, or millia by any method up to 14 lesions not allowed same date of service as related 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.
1365	**Destruction of warts, molluscum contagiosum, or millia by any method of fifteen or more lesions not allowed same date of service as related 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.
1366	**Excision of chest wall tumor without mediastinal lymphadenectomy not allowed same date of service as related 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.

1367	**Excision of chest will tumor without mediastinal lymphadenectomy not allowed same date of service as related procedures.**	**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.
1368	**Vertbebral corpectomy, partial or complete, each additional segment must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1368	**Vertbebral corpectomy, partial or complete, each additional segment must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1369	**Injection, anesthetic agent; trigeminal nerve, paravertebral facet joint nerve, each additional level must bill with primary.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1369	**Injection, anesthetic agent; trigeminal nerve, paravertebral facet joint nerve, each additional level must bill with primary.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.

1370	**Code W8014 is not allowed on the same date of service as 92551 or 92552**	**B5**	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated.	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
1371	**Destruction by neurolytic agent; paravertebral facet joint nerve, each additional level must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1371	**Destruction by neurolytic agent; paravertebral facet joint nerve, each additional level must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1372	**Excision of neuroma; digital nerve, each additional digit must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1372	**Excision of neuroma; digital nerve, each additional digit must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1373	**Excision of neuroma, hand or foot, each additional nerve must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.

1373	**Excision of neuroma, hand or foot, each additional nerve must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1374	**Suture of digital nerve, hand or foot, each additional digital nerve must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1374	**Suture of digital nerve, hand or foot, each additional digital nerve must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1375	**Fetal nonstress included in fetal biophysical profile.**	**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.
1376	**Suture of each additional nerve; hand or foot, must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.

1376	**Suture of each additional nerve; hand or foot, must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1377	**Suture of each additional major peripheral nerve must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1377	**Suture of each additional major peripheral nerve must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1378	**Related DME procedures are not allowed on the same date of service.**	**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.
1379	**Service included in ob package 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.

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.
1383	**Nerve graft, each additional nerve, single strand must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1383	**Nerve graft, each additional nerve, single strand must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1384	**Related strabismus surgery must be billed with primary.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1384	**Related strabismus surgery must be billed with primary.**	**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.		
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.

1386	**Exceeds 50 procedures per day limitation.**	**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.
1386	**Exceeds 50 procedures per day limitation.**	**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
1387	**Related strabismus surgery must be billed with primary.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1387	**Related strabismus surgery must be billed with primary.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1388	**Thoracic, add'l 2nd, 3rd and beyond order must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1388	**Thoracic, add'l 2nd, 3rd and beyond order must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1389	**Exceeds three procedures per three day limitation.**	**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.

1389	**Exceeds three procedures per three day 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.
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.
1391	**Family planning should not be indicated. Please correct and resubmit as a new day claim.**	**125**	Submission-billing error(s)	**N56**	Procedure code billed is not correct-valid for the service 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.
1391	**Family planning should not be indicated. Please correct and resubmit as a new day claim.**	**125**	Submission-billing error(s)	**N56**	Procedure code billed is not correct-valid for the service billed or the date of service billed.	**568**	Family Planning Indicator
1392	**Additional hour for work hardening-conditional must be billed with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1392	**Additional hour for work hardening-conditional must be billed with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
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)

1394	**Three teleconsult visits 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.
1394	**Three teleconsult visits allowed per day.**	**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.
1394	**Three teleconsult visits 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
1394	**Three teleconsult visits allowed per day.**	**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	**612**	Per Day Limit Amount
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.
1396	**Observation is not routinely allowed. Submit as adjustment with documentation to substantiate the medical necessity.**	**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.
1396	**Observation is not routinely allowed. Submit as adjustment with documentation to substantiate the medical necessity.**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes- summary- report- chart	**287**	Medical necessity for service.
1396	**Observation is not routinely allowed. Submit as adjustment with documentation to substantiate the medical necessity.**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes- summary- report- chart	**294**	Supporting documentation.
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.

1398	**Preventive medicine, individual and group counseling not allowed more than 10 per calendar 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.	**259**	Frequency of service.
1398	**Preventive medicine, individual and group counseling not allowed more than 10 per calendar year.**	**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.
1399	**Bill Medicare 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.
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.
1401	**Detailed and extensive oral evaluation-problem focused, by report not allowed same date of service as dental exam.**	**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.

1402	**Dental exam not allowed on the same date of service detailed and extensive oral evaluation.**	**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.
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.	**259**	Frequency of service.
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
1404	**Private insurance payment indicated on claim. No record of TPL on file. correct claim or update recipient TPL using DMA form 2057 and resubmit claim.**	**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.
1404	**Private insurance payment indicated on claim. No record of TPL on file. correct claim or update recipient TPL using DMA form 2057 and resubmit claim.**	**22**	This care may be covered by another payer per coordination of benefits.	**N155**	**Alert-** Our records do not indicate that other insurance is on file. Please submit other insurance information for our records	**116**	Claim submitted to incorrect payer.
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.

1406	**Large volume nebulizer not allowed same month as compressor.**	**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.	**58**	Days-units for procedure-revenue code.
1407	**Only one continuous epidural analgesia allowed per 270 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.
1407	**Only one continuous epidural analgesia allowed per 270 days.**	**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.
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.
1409	**HCPC code not appropriate with non-Medicare beneficiary. Please correct and resubmit.**	**125**	Submission-billing error(s)	**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.
1409	**HCPC code not appropriate with non-Medicare beneficiary. Please correct and resubmit.**	**125**	Submission-billing error(s)	**M56**	Missing-incomplete-invalid payer identifier	**454**	Procedure code for services rendered.
1410	**Revenue code must be billed with a skilled nursing visit HCPC code.**	**125**	Submission-billing error(s)	**M20**	Missing-incomplete-invalid HCPCS.	**454**	Procedure code for services rendered.
1410	**Revenue code must be billed with a skilled nursing visit HCPC code.**	**125**	Submission-billing error(s)	**M50**	Missing-incomplete-invalid revenue code(s).	**454**	Procedure code for services rendered.
1410	**Revenue code must be billed with a skilled nursing visit HCPC code.**	**125**	Submission-billing error(s)	**M20**	Missing-incomplete-invalid HCPCS.	**455**	Revenue code for services rendered.

1410	**Revenue code must be billed with a skilled nursing visit HCPC code.**	**125**	Submission-billing error(s)	**M50**	Missing-incomplete-invalid revenue code(s).	**455**	Revenue code for services rendered.
1411	**Allow one oral evaluation every three months.**	**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.
1411	**Allow one oral evaluation every three months.**	**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.
1412	**Only six oral evaluations and flouride varnish applications allowed per recipient's lifetime.**	**149**	Lifetime benefit maximum has been reached for this service-benefit category	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
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**	**45**	Charge exceeds fee schedule-	**N45**	Payment based on authorized	**64**	Re-pricing information.
					between this service-procedure-		

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.
1417	**Diagnostic arthroscopy not allowed on the same date of service as surgical arthroscopy.**	**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.
1418	**No payment allowed for special services procedure when e-m service is not paid for the same date of service, same provider.**	**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.
1419	**Surgical arthroscopy (D7873, 29804) not allowed on the same date of service as TMJ.**	**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.
1420	**Unit cutback - exceeds max units allowed.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.

1420	**Unit cutback - exceeds max units allowed.**	**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.
1420	**Unit cutback - exceeds max units allowed.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
1420	**Unit cutback - exceeds max units allowed.**	**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.
1420	**Unit cutback - exceeds max units allowed.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**476**	Missing or invalid units of service
1420	**Unit cutback - exceeds max units allowed.**	**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	**476**	Missing or invalid units of service
1421	**Repair of maxillofacial soft or hard tissue defects not allowed on the same date of service as related dental 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.

1422	**Immunization administration not allowed without billing the appropriate immunization 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.	**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.
1422	**Immunization administration not allowed without billing the appropriate immunization 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**490**	Other proedure code for service(s) rendered.
1423	**D7850, D7860 or D7865 not allowed on the same date of service as arthroplasty (21242 or 21243).**	**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.
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.
1425	**Athroplasty is only allowed once for the same joint 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.	**259**	Frequency of service.

1426	**Injectable drug administration not allowed on same date of service as iv infusion therapy.**	**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.
1427	**Iv infusion therapy not allowed on same date of service as injectable drug administration. injectable drug administration fee recouped.**	**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.
1428	**Additional burn and wound preparation must be billed same date of service as primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1428	**Additional burn and wound preparation must be billed same date of service as primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1429	**Additional application of allograft, skin must be billed same date of service as primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.

1429	**Additional application of allograft, skin must be billed same date of service as primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1430	**Additional application of xenogaft, skin must be billed same date of service as primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1430	**Additional application of xenogaft, skin must be billed same date of service as primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1431	**Additional vein related procedures must be billed same date of service as primary procedures.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1431	**Additional vein related procedures must be billed same date of service as primary procedures.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1432	**Detail billed with incorrect or no modifier. Correct detail and resubmit as a new day claim. If reimbursement affected request a full recoupment and resubmit 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**	**453**	Procedure code modifier(s) for service(s) rendered.

1433	**Exceeds 4 units per 270 day limitation.**	**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.
1433	**Exceeds 4 units per 270 day 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.
1433	**Exceeds 4 units per 270 day 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.
1434	**Related dialysis graft procedures not allowed 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.
1435	**Related pelvic exenteraton procedures not allowed to bill with 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.

1436	**Related vaginectomy procedures not allowed 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.
1437	**Thyroid carcinoma metastases uptake must be billed same DOS as imaging whole body.**	**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.	**454**	Procedure code for services rendered.
1437	**Thyroid carcinoma metastases uptake must be billed same DOS as imaging whole body.**	**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.	**454**	Procedure code for services rendered.
1438	**Related cardiac blood pool imaging must be billed same DOS as primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1438	**Related cardiac blood pool imaging must be billed same DOS as primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.

1439	**Amino acids; single qualitative, each specimen not allowed same DOS as multiple.**	**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.
1440	**Bilirubin; total or direct not allowed same DOS as total and direct.**	**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.
1441	**2 to 5 amino acids not allowed same DOS as 6 or more amino acids.**	**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.
1442	**One unit allowed with base code, correct all units on your claim and resubmit.**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**259**	Frequency of service.
1443	**Specially priced claim through DMA. Correct to appropriate 11X or 89X bill type and resubmit to HPES.**	**125**	Submission-billing error(s)	**MA30**	Missing-incomplete-invalid type of bill.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

1444	**Group speech-language therapy service not allowed same date of service as individual speech-language therapy service.**	**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.
1445	**Group speech-language therapy services recouped. Group speech-language treatment not allowed same day as individual speech-language treatment.**	**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.
1446	**Only one Case Management allowed per month. Case management billed through another program has already been paid this month.**	**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.

1447	**Stable isotope dilution not allowed to bill with multiple.**	**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.
1448	**Parathyroid autotransplantation must bill with primary proc.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1448	**Parathyroid autotransplantation must bill with primary proc.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
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.

1451	**Radiologic exam, knee; minimum of 3 views not allowed to bill with related 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.
1452	**Radiologic exam, knee, complete view not allowed to bill with related 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.
1453	**Intravascular ultrasound, radiological interpretation, each add'l vessel must be billed with primary proc.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1453	**Intravascular ultrasound, radiological interpretation, each add'l vessel must be billed with primary proc.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1454	**Less severe duplicate. professional.**	**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.

1455	**Transluminal balloon angioplasty, each additional peripheral artery must bill with primary procedure**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1455	**Transluminal balloon angioplasty, each additional peripheral artery must bill with primary procedure**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1456	**Transluminal artherectomy, ea add'l peripheral artery must bill with primary proc.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1456	**Transluminal artherectomy, ea add'l peripheral artery must bill with primary proc.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1457	**Transluminal artherectomy, each add'l visceral artery must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1457	**Transluminal artherectomy, each add'l visceral artery must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.

1458	**Liver imaging procedures not allowed to bill with 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.
1459	**Liver imaging with vascular flow not allowed to bill with 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.
1460	**Cardiac blood pool imaging, gated equilibrium not allowed to bill with multiple studies.**	**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.
1461	**Performance of the test physician supervision, report and interpretation included in the cardiac stress test.**	**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.

1462	**Myocardial perfusion study must bill with related procedure.**	**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.	**454**	Procedure code for services rendered.
1462	**Myocardial perfusion study must bill with related procedure.**	**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.	**454**	Procedure code for services rendered.
1463	**Only one special services visit 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.
1463	**Only one special services visit 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
1464	**Amino acids, qualitative not allowed to bill with multiple.**	**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.

1465	**Chromatography, quantitative, column not allowed to bill with multiple.**	**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.
1466	**Immunoassay for analyte other than antibody agent antigen, multiple step method not allowed to bill with single**	**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.
1467	**Immunoassay for analyte other than infectious agent for single step method not allowed with multiple step method.**	**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.

1468	**Chromatography, quantitative, column, multiple analytes not allowed same DOS as single analyte.**	**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.
1469	**Infectious agent analysis not allowed with HIV resistance testing.**	**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.
1470	**Molecular diagnostics not allowed to bill with multiplex.**	**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.

1471	**Components of HIV resistance testing recouped. components not allowed same day as HIV resistance testing.**	**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.
1472	**IV infusion for therapy-diagnosis must be billed with primary.**	**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.	**454**	Procedure code for services rendered.
1472	**IV infusion for therapy-diagnosis must be billed with primary.**	**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.	**454**	Procedure code for services rendered.
1473	**Use of vertical electrodes must bill with primary procedures.**	**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.	**454**	Procedure code for services rendered.
1473	**Use of vertical electrodes must bill with primary procedures.**	**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.	**454**	Procedure code for services rendered.

1474	**Transcatheter placement of an intracoronary stent, each add'l vessel must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1474	**Transcatheter placement of an intracoronary stent, each add'l vessel must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1475	**Percutaneous transluminal coronary balloon angioplasty; single vessel must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1475	**Percutaneous transluminal coronary balloon angioplasty; single vessel must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1476	**Percutaneous balloon valvuloplasty; aortic valve must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1476	**Percutaneous balloon valvuloplasty; aortic valve must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.

1477	**Percutaneous transluminal pulmonary artery balloon angioplasty, each add'l vessel must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1477	**Percutaneous transluminal pulmonary artery balloon angioplasty, each add'l vessel must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1478	**Doppler echocardiography, pulsed wave; complete must bill with related procedure.**	**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.	**454**	Procedure code for services rendered.
1478	**Doppler echocardiography, pulsed wave; complete must bill with related procedure.**	**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.	**454**	Procedure code for services rendered.
1479	**Doppler echocardiography, pulsed wave: follow up must bill with related procedure.**	**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.	**454**	Procedure code for services rendered.
1479	**Doppler echocardiography, pulsed wave: follow up must bill with related procedure.**	**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.	**454**	Procedure code for services rendered.

1480	**Pulmonary stress testing, simple not allowed to bill with complex.**	**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.
1481	**Cardiac stress test includes performance of the test, physician supervision, interpretation and report.**	**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.
1482	**Intraoperative neurophysilogy testing, per hour must be billed with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1482	**Intraoperative neurophysilogy testing, per hour must be billed with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1483	**Doppler color flow velocity mapping must bill with related procedure.**	**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.	**454**	Procedure code for services rendered.

1483	**Doppler color flow velocity mapping must bill with related procedure.**	**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.	**454**	Procedure code for services rendered.
1484	**Hepatitis a vaccine, pediatric-adolescent dosage, 2 dose schedule must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1484	**Hepatitis a vaccine, pediatric-adolescent dosage, 2 dose schedule must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1485	**Hepatitis a vaccine, adult dosage, for intramuscular use must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1485	**Hepatitis a vaccine, adult dosage, for intramuscular use must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
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.

1487	**Electronic analysis of implanted neurostimulator pulse generated must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1487	**Electronic analysis of implanted neurostimulator pulse generated must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1488	**Intravascular doppler velocity must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1488	**Intravascular doppler velocity must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1489	**Rotavirus vaccine, tentravalent, live for oral use must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1489	**Rotavirus vaccine, tentravalent, live for oral use must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.

1490	**Use of operating microscope not allowed with primary procedure.**	**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	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
1491	**Prolonged physician service in the inpatient setting must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1491	**Prolonged physician service in the inpatient setting must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1492	**Prolonged physician service in the office must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1492	**Prolonged physician service in the office must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1493	**Critical care, evaluation and mgmt must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.

1493	**Critical care, evaluation and mgmt must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1494	**Payment included in multiple tendons, bilateral.**	**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.
1495	**Chemotherapy administration, intra-arterial; infusion tech, 1 to 8 hours; each additional hour must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1495	**Chemotherapy administration, intra-arterial; infusion tech, 1 to 8 hours; each additional hour must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1496	**Chemotherapy administration, intravenous, infusion tech, up to 1 hour must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.

1496	**Chemotherapy administration, intravenous, infusion tech, up to 1 hour must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1497	**Each additional hour of physician attendance must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1497	**Each additional hour of physician attendance must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1498	**Strabismus surgery, repair of detached extraocular muscle must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1498	**Strabismus surgery, repair of detached extraocular muscle must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1499	**Bill Medicare Part B or Prescription Drug Plan**	**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.

1500	**Medicaid does not make separate payment for procedures that are components of a more comprehensive service already paid for the same date of service.**	**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.
1501	**Enterectomy, resection of small intestine, each add'l resection must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1501	**Enterectomy, resection of small intestine, each add'l resection must bill with primary procedure.**	**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.	**454**	Procedure code for services rendered.
1502	**Components denied. Rebill using 81000 as the complete procedure, versus multiple components of urinalysis.**	**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.
1503	**Diskectomy, cervical, each add'l interspace must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.

1503	**Diskectomy, cervical, each add'l interspace must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1504	**Cytopathology definitive hormonal evaluation related p codes must be billed same DOS.**	**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.	**454**	Procedure code for services rendered.
1504	**Cytopathology definitive hormonal evaluation related p codes must be billed same DOS.**	**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.	**454**	Procedure code for services rendered.
1505	**Tenotomy, single included in multiple.**	**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.
1506	**Procedure denied. bronchoplasty procedure only allowed when billed in addition to primary surgery procedure. Review claim, correct and resubmit as a new claim.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.

1506	**Procedure denied. bronchoplasty procedure only allowed when billed in addition to primary surgery procedure. Review claim, correct and resubmit as a new claim.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1507	**Multiple osteotomy of metatarsals not allowed on same date.**	**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.
1508	**Multiple arthrodesis procedures not allowed on same date.**	**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.
1509	**Multiple related arthrodesis procedures not allowed on same date.**	**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.

1510	**Multiple capsulodesis procedures not allowed on same date.**	**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.
1511	**Tenotomy, multiple, 1 leg included in bilateral.**	**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.
1512	**Medicaid has paid the maximum allowable for procedure.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
1513	**Professional treatment services in crisis facilities limited to 15 consecutive days. Correct claim and rebill.**	**119**	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.
1514	**Separate reimbursement not allowed when other services are paid on the same date of service.**	**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.

1515	**Bypass graft, composite must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1515	**Bypass graft, composite must bill with primary procedure.**	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
1516	**Foreskin manipulation included in related procedure 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.
1517	**Removal of vitreous included in extracapsular cataract procedure 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.

1518	**Enterolysis included in intestinal procedures same date of service**	**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.
1519	**Component of procedure (either technical or professional denied because same procedure code has already been reimbursed as a complete procedure for this date of service.**	**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.
1520	**Technical component of this procedure has already been reimbursed for this date. Rebill for professional component only.**	**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.

1521	**Professional component of this procedure code has already been reimbursed for this date. Rebill for technical component only.**	**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.
1522	**No payment for add-on (zzz) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
1522	**No payment for add-on (zzz) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
1523	**No payment for add-on (zzz) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
1523	**No payment for add-on (zzz) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.

1524	**No payment for add-on (zzz) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
1524	**No payment for add-on (zzz) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
1525	**Related removal of venous access device 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.
1526	**Related removal of venous access device 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.
1527	**No payment for add-on (zzz) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.

1527	**No payment for add-on (zzz) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
1528	**Reimbursement for monthly rental of DME includes payment for related supplies.**	**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.
1529	**Payment for supplies recouped to allow reimbursement for monthly rental of related DME.**	**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.
1530	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
1530	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.

1531	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
1531	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
1532	**Residential evaluation service not allowed same DOS as CAP Case Management.**	**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.
1533	**Residential evaluation service recouped. Service not allowed same DOS as CAP case management.**	**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.

1534	**Residential evaluation services not allowed same DOS as HRI.**	**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.
1535	**Residential evaluation services not allowed during inpatient or nursing home stay.**	**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.	**M2**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
1536	**Residential evaluation service recouped. Service not allowed during inpatient or nursing home stay.**	**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.	**M2**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
1537	**Units were changed to allow a maximum of 14 units per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
1537	**Units were changed to allow a maximum of 14 units per day.**	**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.
1537	**Units were changed to allow a maximum of 14 units per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.

1537	**Units were changed to allow a maximum of 14 units per day.**	**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.
1537	**Units were changed to allow a maximum of 14 units per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
1537	**Units were changed to allow a maximum of 14 units per day.**	**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	**612**	Per Day Limit Amount
1538	**Graft procedure denied. Graft procedure only allowed when billed in addition to spinal operative session, same date of service.**	**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.	**454**	Procedure code for services rendered.
1538	**Graft procedure denied. Graft procedure only allowed when billed in addition to spinal operative session, same date of service.**	**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.	**454**	Procedure code for services rendered.
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 prophy 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.

1541	**E-M visit not allowed same date of service as clinic visit.**	**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.
1542	**Clinic visit not allowed same date of service as E-M visit.**	**B15**	This service-procedure requires that a qualifying service-procedure be received and	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
	Value Options (888-510-1150) is						

1546	**Psychotherapy & E-M cannot be billed as separate procedure. Previously billed E-M procedure will be recouped. Rebill the appropriate psychotherapy code that includes medical E-M.**	**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.
1547	**Service recouped. E-M billed on same date of service as psychotherapy. Rebill using the appropriate psychotherapy code that includes medical evaluation and management.**	**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.
1548	**Exceeds unmanaged mental health visit limitation.**	**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.
1549	**Recipient must have received EPO therapy on the same date of service or within 3 months prior to the date of service of ferrlecit or iron sucrose.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N19**	Procedure code incidental to primary procedure.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1549	**Recipient must have received EPO therapy on the same date of service or within 3 months prior to the date of service of ferrlecit or iron sucrose.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N161**	This drug-service-supply is covered only when the associated service is covered.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1549	**Recipient must have received EPO therapy on the same date of service or within 3 months prior to the date of service of ferrlecit or iron sucrose.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.

1549	**Recipient must have received EPO therapy on the same date of service or within 3 months prior to the date of service of ferrlecit or iron sucrose.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N161**	This drug-service-supply is covered only when the associated service is covered.	**454**	Procedure code for services rendered.
1550	**DME equipment allowed twice per year.**	**108**	Rent-purchase guidelines were not met. Note- Refer to the 835	**M86**	Service denied because payment already made for	**259**	Frequency of service.
					between this service-procedure-		

1554	**Service recouped. nursing home-ach service not allowed during inpatient stay.**	**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.	**M2**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
1555	**DME equipment allowed twice in two years.**	**108**	Rent-purchase guidelines were not met. 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.
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.
1560	**Provider must split details between UB with the revenue code and CMS-1500 with the HCPCS 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.

1560	**Provider must split details between UB with the revenue code and CMS-1500 with the HCPCS 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.	**481**	Claim submission format is invalid.
1561	**RES not allowed same DOS as maternity care coordination.**	**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.
1562	**RES recouped. service not allowed during same DOS as maternity care coordination.**	**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.
1563	**Revenue Code for Skilled Nursing Visit has been billed with an invalid HCPCS code**	**125**	Submission-billing error(s)	**M50**	Missing-incomplete-invalid revenue code(s).	**454**	Procedure code for services rendered.
1563	**Revenue Code for Skilled Nursing Visit has been billed with an invalid HCPCS code**	**125**	Submission-billing error(s)	**M51**	Missing-incomplete-invalid, procedure code(s) and-or dates	**454**	Procedure code for services rendered.
1563	**Revenue Code for Skilled Nursing Visit has been billed with an invalid HCPCS code**	**125**	Submission-billing error(s)	**M50**	Missing-incomplete-invalid revenue code(s).	**455**	Revenue code for services rendered.

1563	**Revenue Code for Skilled Nursing Visit has been billed with an invalid HCPCS code**	**125**	Submission-billing error(s)	**M51**	Missing-incomplete-invalid, procedure code(s) and-or dates	**455**	Revenue code for services rendered.
1564	**RES recouped. service not allowed same DOS as HRI.**	**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.
1565	**Miscellaneous charges not allowed with prolonged services or critical care.**	**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.
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.

1567	**Alcohol-drug intensive outpatient services not allowed during inpatient stay**	**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.
1568	**Personal Care Services and Private Duty Nursing are no longer billed on the UB. Rebill on the CMS 1500.**	**16**	Claim-service lacks information which is needed for adjudication	**N34**	Incorrect claim form-format for this service.	**481**	Claim-submission format is invalid.
1569	**PCS not allowed same days as HRI-RI facility.**	**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.	**259**	Frequency of service.
1570	**Recoup PCS when HRI-RI is 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.	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.

1571	**Adj. Denied. Records do not support individual transports. A recoupment has been initiated for the individual transport previously paid. Resubmit claim for round trip trans after recoup occurs**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**N20**	Service not payable with other service rendered on the same date.	**267**	Number of miles patient was transported
1571	**Adj. Denied. Records do not support individual transports. A recoupment has been initiated for the individual transport previously paid. Resubmit claim for round trip trans after recoup occurs**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**N56**	Procedure code billed is not correct-valid for the services billed or the date of service billed.	**267**	Number of miles patient was transported
1571	**Adj. Denied. Records do not support individual transports. A recoupment has been initiated for the individual transport previously paid. Resubmit claim for round trip trans after recoup occurs**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**N152**	Missing-incomplete-invalid replacement claim information.	**267**	Number of miles patient was transported
1571	**Adj. Denied. Records do not support individual transports. A recoupment has been initiated for the individual transport previously paid. Resubmit claim for round trip trans after recoup occurs**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**N20**	Service not payable with other service rendered on the same date.	**294**	Supporting documentation.
1571	**Adj. Denied. Records do not support individual transports. A recoupment has been initiated for the individual transport previously paid. Resubmit claim for round trip trans after recoup occurs**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**N56**	Procedure code billed is not correct-valid for the services billed or the date of service billed.	**294**	Supporting documentation.

1571	**Adj. Denied. Records do not support individual transports. A recoupment has been initiated for the individual transport previously paid. Resubmit claim for round trip trans after recoup occurs**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**N152**	Missing-incomplete-invalid replacement claim information.	**294**	Supporting documentation.
1571	**Adj. Denied. Records do not support individual transports. A recoupment has been initiated for the individual transport previously paid. Resubmit claim for round trip trans after recoup occurs**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**N20**	Service not payable with other service rendered on the same date.	**472**	Ambulance Run Sheet
1571	**Adj. Denied. Records do not support individual transports. A recoupment has been initiated for the individual transport previously paid. Resubmit claim for round trip trans after recoup occurs**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**N56**	Procedure code billed is not correct-valid for the services billed or the date of service billed.	**472**	Ambulance Run Sheet
1571	**Adj. Denied. Records do not support individual transports. A recoupment has been initiated for the individual transport previously paid. Resubmit claim for round trip trans after recoup occurs**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**N152**	Missing-incomplete-invalid replacement claim information.	**472**	Ambulance Run Sheet
1572	**Units cutback. Units billed exceed maximum units allowed**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
1572	**Units cutback. Units billed exceed maximum units allowed**	**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.

1572	**Units cutback. Units billed exceed maximum units allowed**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
1572	**Units cutback. Units billed exceed maximum units allowed**	**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.
1573	**Case Management paid to DMH recouped to allow payment for Case Management to CAP provider for the same date of service**	**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.
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.
1575	**Inpatient services billed same day PDN, not allowed**	**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.	**259**	Frequency of service.

1576	**CAP Recipients are not eligible for at-risk case management services**	**177**	Patient has not met the required eligibility requirements.	**N30**	Patient ineligible for this service.	**90**	Entity not eligible for medical benefits for submitted dates of service. Note- This code requires use of an Entity Code.
1577	**Canal and pulpotomy procedures not allowed for the same tooth, same date of 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.
1578	**Pulpotomy procedure included in reimbursement for root canal**	**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.
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.
1580	**Recipient must be undergoing chronic hemodialysis (RC821).**	**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.	**454**	Procedure code for services rendered.

1581	**Hospice patient. Contact hospice responsible for patient care. Refile claim only for date(s) of service not covered by Hospice Benefit.**	**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.	**457**	Non-Covered Day(s)
1582	**Exceeds maximum number of physical therapy modalities (6) allowed per day for dental provider.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1582	**Exceeds maximum number of physical therapy modalities (6) allowed per day for dental provider.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
1582	**Exceeds maximum number of physical therapy modalities (6) allowed per day for dental provider.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**442**	Modalities of service.
1582	**Exceeds maximum number of physical therapy modalities (6) allowed per day for dental provider.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**442**	Modalities of service.
1582	**Exceeds maximum number of physical therapy modalities (6) allowed per day for dental provider.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
1582	**Exceeds maximum number of physical therapy modalities (6) allowed per day for dental provider.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount
1583	**Hospice and PDN services not allowed same day. PDN claim paid for this date of service**	**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.	**187**	Date(s) of service.

1584	**Procedure allowed once 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.
1584	**Procedure allowed once 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
1585	**ONLY ONE X-RAY PROCEDURE ALLOWED FOR THIS PROVIDER WITHIN A 6 MONTH PERIOD. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION TO SUPPORT NECESSITY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	**S**ervice denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

1585	**ONLY ONE X-RAY PROCEDURE ALLOWED FOR THIS PROVIDER WITHIN A 6 MONTH PERIOD. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION TO SUPPORT NECESSITY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N29**	Missing documentation-orders-notes-summary-report-chart.	**259**	Frequency of service.
1585	**ONLY ONE X-RAY PROCEDURE ALLOWED FOR THIS PROVIDER WITHIN A 6 MONTH PERIOD. RESUBMIT AS AN**	**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.
					between this service-procedure-		

1585	**ONLY ONE X-RAY PROCEDURE ALLOWED FOR THIS PROVIDER WITHIN A 6 MONTH PERIOD. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION TO SUPPORT NECESSITY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	**S**ervice denied because payment already made for same-similar procedure within set time frame.	**287**	Medical necessity for service.
1585	**ONLY ONE X-RAY PROCEDURE ALLOWED FOR THIS PROVIDER WITHIN A 6 MONTH PERIOD. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION TO SUPPORT NECESSITY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N29**	Missing documentation-orders-notes-summary-report-chart.	**287**	Medical necessity for service.
					between this service-procedure-		

1588	**Claim denied. Treatment has been rendered by another provider for this date of service**	**B20**	Procedure-service was partially or fully furnished by another provider.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
1589	**Only one incision allowed per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1589	**Only one incision allowed per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
1590	**No PASARR number on file at HP. Contact First Health Services at 1-800-639-6514.**	**197**	Precertification-authorization-notification absent.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**48**	Referral-authorization.
1591	**Dates of service not within authorized PASARR time period. Contact First Health Services at 1-800-639-6514.**	**197**	Precertification-authorization-notification absent.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**48**	Referral-authorization.
1592	**Service requires PASARR authorization for admission to a Medicaid certified Nursing Facility. Contact First Health Services at 1-800-639-6514.**	**197**	Precertification-authorization-notification absent.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**48**	Referral-authorization.
1593	**Service denied. Exceeds the maximum units allowed per month**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
1593	**Service denied. Exceeds the maximum units allowed per month**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	
1593	**Service denied. Exceeds the maximum units allowed per month**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
1593	**Service denied. Exceeds the maximum units allowed per month**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service

1595	**Nutritional services limited to one per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1595	**Nutritional services limited to one per date of service.**	**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.
1595	**Nutritional services limited to one per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
1595	**Nutritional services limited to one per date of service.**	**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	**612**	Per Day Limit Amount
1596	**Recipient not eligible for CAP services.**	**177**	Patient has not met the required eligibility requirements.	**N30**	Patient ineligible for this service.	**90**	Entity not eligible for medical benefits for submitted dates of service. Note- This code requires use of an Entity Code.
1597	**Provider not enrolled to perform services in recipients benefit package.**	**125**	Submission-billing error(s)	**N30**	Patient ineligible for this service.	**91**	Entity not eligible-not approved for dates of service.
1597	**Provider not enrolled to perform services in recipients benefit package.**	**125**	Submission-billing error(s)	**N95**	This provider type-provider specialty may not bill this service.	**91**	Entity not eligible-not approved for dates of service.
1597	**Provider not enrolled to perform services in recipients benefit package.**	**125**	Submission-billing error(s)	**N152**	Missing-incomplete-invalid replacement claim information.	**91**	Entity not eligible-not approved for dates of service.
1598	**At-Risk Case Management service recouped. This service not allowed when recipient is receiving related case management services.**	**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.	**259**	Frequency of service.

1599	**CAP Respite Care services recouped. This service not allowed when recipient is receiving Adult Care Homes, PCS or Therapeutic Leave.**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
1601	**Detail previously paid and was not reprocessed**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment		**No Mapping Required**	**65**	Claim-line has been paid
1602	**Detail previously denied and was not reprocessed**	**18**	Exact duplicate claim-service		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge
1603	**Payment is included in the allowance for another service or procedure.**	**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	**258**	Days-units for procedure-revenue code
1604	**Synagis Max 25-day QTY rules exceeded. Synagis rules allow no more than one 50mg vial and no more than 250mg total in any 25-day period.**	**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	**216**	Drug information.
1604	**Synagis Max 25-day QTY rules exceeded. Synagis rules allow no more than one 50mg vial and no more than 250mg total in any 25-day period.**	**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.
1604	**Synagis Max 25-day QTY rules exceeded. Synagis rules allow no more than one 50mg vial and no more than 250mg total in any 25-day period.**	**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

1605	**Service denied, recipient eligible for only emergency services.**	**177**	Patient has not met the required eligibility requirements.	**N30**	Patient ineligible for this service.	**90**	Entity not eligible for medical benefits for submitted dates of service. Note- This code requires use of an Entity Code.
1606	**Service denied. Recipient eligible for only emergency services. Please resubmit as an adjustment with supporting documentation if an emergency situation existed.**	**177**	Patient has not met the required eligibility requirements.	**N30**	Patient ineligible for this service.	**90**	Entity not eligible for medical benefits for submitted dates of service. Note- This code requires use of an Entity Code.
1606	**Service denied. Recipient eligible for only emergency services. Please resubmit as an adjustment with supporting documentation if an emergency situation existed.**	**177**	Patient has not met the required eligibility requirements.	**N95**	This provider type-provider specialty may not bill this service.	**90**	Entity not eligible for medical benefits for submitted dates of service. Note- This code requires use of an Entity Code.
1606	**Service denied. Recipient eligible for only emergency services. Please resubmit as an adjustment with supporting documentation if an emergency situation existed.**	**177**	Patient has not met the required eligibility requirements.	**N152**	Missing-incomplete-invalid replacement claim information.	**90**	Entity not eligible for medical benefits for submitted dates of service. Note- This code requires use of an Entity Code.
1606	**Service denied. Recipient eligible for only emergency services. Please resubmit as an adjustment with supporting documentation if an emergency situation existed.**	**177**	Patient has not met the required eligibility requirements.	**N30**	Patient ineligible for this service.	**294**	Supporting documentation
1606	**Service denied. Recipient eligible for only emergency services. Please resubmit as an adjustment with supporting documentation if an emergency situation existed.**	**177**	Patient has not met the required eligibility requirements.	**N95**	This provider type-provider specialty may not bill this service.	**294**	Supporting documentation

1606	**Service denied. Recipient eligible for only emergency services. Please resubmit as an adjustment with supporting documentation if an emergency situation existed.**	**177**	Patient has not met the required eligibility requirements.	**N152**	Missing-incomplete-invalid replacement claim information.	**294**	Supporting documentation
1607	**Service denied. Supporting documentation does not indicate an emergency situation.**	**177**	Patient has not met the required eligibility requirements.	**N30**	Patient ineligible for this service.	**90**	Entity not eligible for medical benefits for submitted dates of service. Note- This code requires use of an Entity Code.
1607	**Service denied. Supporting documentation does not indicate an emergency situation.**	**177**	Patient has not met the required eligibility requirements.	**N30**	Patient ineligible for this service.	**294**	Supporting documentation
1608	**Recipient eligible for emergency services only. Please resubmit as an Adj. placing non-emerg. charges (i.e., steri) in non-covered column & note change in Remarks field.**	**177**	Patient has not met the required eligibility requirements.	**N30**	Patient ineligible for this service.	**294**	Supporting documentation
1609	**CLAIM INCLUDES FAMILY PLANNING DIAGNOSIS(ES) AND NO FAMILY PLANNING PROCEDURE. PLEASE RESUBMIT WITH FAMILY PLANNING PROCEDURE-MODIFIER OR CORRECT THE DIAGNOSIS.**	**11**	The diagnosis is inconsistent with the procedure.	**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.
1609	**CLAIM INCLUDES FAMILY PLANNING DIAGNOSIS(ES) AND NO FAMILY PLANNING PROCEDURE. PLEASE RESUBMIT WITH FAMILY PLANNING PROCEDURE-MODIFIER OR CORRECT THE DIAGNOSIS.**	**11**	The diagnosis is inconsistent with the procedure.	**M76**	Missing-incomplete-invalid diagnosis or condition.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.

1609	**CLAIM INCLUDES FAMILY PLANNING DIAGNOSIS(ES) AND NO FAMILY PLANNING PROCEDURE. PLEASE RESUBMIT WITH FAMILY PLANNING PROCEDURE-MODIFIER OR CORRECT THE DIAGNOSIS.**	**11**	The diagnosis is inconsistent with the procedure.	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered
1610	**FAMILY PLANNING PROCEDURE CODE REQUIRES FAMILY PLANNING DIAGNOSIS. PLEASE CORRECT AND RESUBMIT.**	**11**	The diagnosis is inconsistent with the procedure.	**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.
1610	**FAMILY PLANNING PROCEDURE CODE REQUIRES FAMILY PLANNING DIAGNOSIS. PLEASE CORRECT AND RESUBMIT.**	**11**	The diagnosis is inconsistent with the procedure.	**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.
1611	**Service has already been paid to another provider for same DOS**	**B20**	Procedure-service was partially or fully furnished by another provider.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1611	**Service has already been paid to another provider for same DOS**	**B20**	Procedure-service was partially or fully furnished by another provider.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
1612	**Claim paid without TPL deduction. Original claim reduced allowable using remaining available TPL**	**23**	The impact of prior payer(s) adjudication including payments and-or adjustments		**No Mapping Required**	**182**	Allowable-paid from primary coverage
1613	**Service not allowed for a DME or HIT provider - Please resubmit on a pharmacy claim only if recipient is eligible for cost sharing**	**A1**	Claim-Service denied	**N34**	Incorrect claim form-format for this service.	**481**	Claim-submission format is invalid.

1614	**Exceeds maximum allowed for a primary posterior composite on a a single tooth**	**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.
1615	**Claim denied. More than one diagnosis code within range 76400 - 76519**	**167**	This (these) diagnosis(es) is (are) not covered. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
1615	**Claim denied. More than one diagnosis code within range 76400 - 76519**	**167**	This (these) diagnosis(es) is (are) not covered. 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	**M64**	Missing-incomplete-invalid other diagnosis.	**488**	Diagnosis code(s) for the services rendered.
1616	**The procedure billed requires a modifier 26 to establish the professional component was billed. Correct your claim and resubmit**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**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.
1616	**The procedure billed requires a modifier 26 to establish the professional component was billed. Correct your claim and resubmit**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered

1617	**The attending provider number cannot be used as a billing provider number. Add the correct billing provider number and resubmit as a new day claim**	**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.
1618	**The LT or RT modifier must be on the same detail line as the NU modifier. Add the appropriate modifier and resubmit the claim.**	**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.
1618	**The LT or RT modifier must be on the same detail line as the NU modifier. Add the appropriate modifier and resubmit the claim.**	**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
1619	**The LT or RT modifier must be billed with procedure code billed. Add the appropriate modifier and resubmit the claim**	**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.
1619	**The LT or RT modifier must be billed with procedure code billed. Add the appropriate modifier and resubmit the claim**	**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
1620	**Certified attending provider number is required when billing this procedure code. Resubmit with appropriate attending number**	**15**	The authorization number is missing, invalid, or does not apply to the billed services or provider	**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.
1620	**Certified attending provider number is required when billing this procedure code. Resubmit with appropriate attending number**	**15**	The authorization number is missing, invalid, or does not apply to the billed services or provider	**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.

1621	**Invalid DRG grouping due to incorrect/insufficient coding. Include weight of newborn on claim and resubmit.**	**A1**	Claim-Service denied	**207**	Missing-incomplete-invalid weight.	**256**	DRG code(s).
1621	**Invalid DRG grouping due to incorrect/insufficient coding. Include weight of newborn on claim and resubmit.**	**A1**	Claim-Service denied	**208**	Missing-incomplete-invalid DRG code.	**256**	DRG code(s).
1621	**Invalid DRG grouping due to incorrect/insufficient coding. Include weight of newborn on claim and resubmit.**	**A1**	Claim-Service denied	**207**	Missing-incomplete-invalid weight.	**273**	Weight.
1621	**Invalid DRG grouping due to incorrect/insufficient coding. Include weight of newborn on claim and resubmit.**	**A1**	Claim-Service denied	**208**	Missing-incomplete-invalid DRG code.	**273**	Weight.
1622	**Intra-Nasal-Oral Administration requires the appropriate Intra-Nasal-Oral Immunization 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.	**M51**	Missing-incomplete-invalid procedure code(s) and-or dates.	**454**	Procedure code for services rendered
1622	**Intra-Nasal-Oral Administration requires the appropriate Intra-Nasal-Oral Immunization 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information.	**454**	Procedure code for services rendered

1622	**Intra-Nasal-Oral Administration requires the appropriate Intra-Nasal-Oral Immunization 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.	**N349**	The administration method and drug must be reported to adjudicate this service.	**454**	Procedure code for services rendered
1623	**First Intra-Nasal-Oral Immunization Administration and first Injectable Immunization Administration not allowed on the same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**259**	Frequency of service
1624	**Incorrect Immunization Administration Code combination billed. This combination cannot be billed on the same date of service. See billing guidelines**	**A1**	Claim-Service denied	**N56**	Procedure code billed is not correct-valid for the services billed or the date of service billed.	**259**	Frequency of service
1625	**No payment for add-on (zzz) code allowed if 'primary' code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
1625	**No payment for add-on (zzz) code allowed if 'primary' code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

1626	**No payment for add-on (zzz) code allowed if 'primary' code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
1626	**No payment for add-on (zzz) code allowed if 'primary' code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
1627	**No payment for add-on (zzz) code allowed if 'primary' code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
1627	**No payment for add-on (zzz) code allowed if 'primary' code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
1628	**Related lab test included in acute hepatitis panel.**	**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.

1629	**Related test to acute hepatitis panel recouped to allow reimbursement of 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.
1630	**DME providers are required to bill modifiers to establish that the procedure billed is new, used or rental. Correct claim and resubmit.**	**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**	**453**	Procedure code modifier(s) for service(s) rendered.
1631	**Gastric Restrictive Procedures limited to one per lifetime.**	**35**	Lifetime benefit maximum has been reached.	**MA35**	Missing-incomplete-invalid number of lifetime reserve days.	**259**	Frequency of service.
1631	**Gastric Restrictive Procedures limited to one per lifetime.**	**35**	Lifetime benefit maximum has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
1632	**Physical therapy re-evaluation not allowed same date of service as Physical therapy evaluation.**	**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.

1633	**Physical therapy evaluation not allowed same date of service as Physical therapy re-evaluation.**	**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.
1634	**Component (either technical or professional) denied. Complete procedure has been reimbursed within 2 years.**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**454**	Procedure code for services rendered.
1635	**Professional component has already been reimbursed within 2 years. Re-bill for technical component only.**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**454**	Procedure code for services rendered.
1636	**Technical component has already been reimbursed within 2 years. Re-bill for professional component only.**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**454**	Procedure code for services rendered.
1637	**Service denied. This test is included in a related panel code already paid for the same date of 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.

1638	**Payment has been reduced to the same total reimbursement as the three surface resin-based composite restoation for a posterior tooth**	**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.
1638	**Payment has been reduced to the same total reimbursement as the three surface resin-based composite restoation for a posterior tooth**	**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.
1639	**For DOS on & After 01-01-2009, procedure requires a secondary modifier of HP, HN, HO, UB, U8, U7, U6 or U5. Refer to the February 2009 NC Medicaid Bulletin for details.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1639	**For DOS on & After 01-01-2009, procedure requires a secondary modifier of HP, HN, HO, UB, U8, U7, U6 or U5. Refer to the February 2009 NC Medicaid Bulletin for details.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**N291**	Missing-incomplete-invalid rending provider secondary identifier.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1639	**For DOS on & After 01-01-2009, procedure requires a secondary modifier of HP, HN, HO, UB, U8, U7, U6 or U5. Refer to the February 2009 NC Medicaid Bulletin for details.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
1639	**For DOS on & After 01-01-2009, procedure requires a secondary modifier of HP, HN, HO, UB, U8, U7, U6 or U5. Refer to the February 2009 NC Medicaid Bulletin for details.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**N291**	Missing-incomplete-invalid rending provider secondary identifier.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.

1640	**For DOS on & after 01-01-2009, Modifiers HP, HN, HO, UB, U8, U7, U6, or U5 must be billed in the secondary position. Refer to the February 2009 NC Medicaid Bulletin for details.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1640	**For DOS on & after 01-01-2009, Modifiers HP, HN, HO, UB, U8, U7, U6, or U5 must be billed in the secondary position. Refer to the February 2009 NC Medicaid Bulletin for details.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**N291**	Missing-incomplete-invalid rending provider secondary identifier.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1640	**For DOS on & after 01-01-2009, Modifiers HP, HN, HO, UB, U8, U7, U6, or U5 must be billed in the secondary position. Refer to the February 2009 NC Medicaid Bulletin for details.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
1640	**For DOS on & after 01-01-2009, Modifiers HP, HN, HO, UB, U8, U7, U6, or U5 must be billed in the secondary position. Refer to the February 2009 NC Medicaid Bulletin for details.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**N291**	Missing-incomplete-invalid rending provider secondary identifier.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
1641	**Unit Cutback. Exceeds maximum units allowed per month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1641	**Unit Cutback. Exceeds maximum units allowed per month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
1641	**Unit Cutback. Exceeds maximum units allowed per month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**483**	Maximum coverage amount met or exceeded for benefit period.

1641	**Unit Cutback. Exceeds maximum units allowed per month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
1642	**Crossover percentage payments are not allowed for this provider type-specialty combination**	**170**	Payment is denied when performed-billed by this type of provider	**N95**	This provider type - provider specialty may not bill this service	**585**	Denied Charge or Non-covered Charge
1643	**Service Denied. Add on administration code must be billed with an appropriate additional immunization code.**	**A1**	Claim-Service denied	**M51**	Missing-incomplete-invalid procedure code(s).	**465**	Principal Procedure Code for Service(s) Rendered
1644	**Service Denied. Federally funded immunization administration not allowed without appropriate administration code.**	**A1**	Claim-Service denied	**M51**	Missing-incomplete-invalid procedure code(s).	**465**	Principal Procedure Code for Service(s) Rendered
1645	**Total time billed for psychological testing is not documented In the medical records. only documented time has been reimbursed.**	**152**	Payer deems the information submitted does not support this length of service. 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.	**297**	Medical notes-report.
1646	**Cap-mr-dd respite care; facility & institutional not allowed same date of service.**	**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.
1647	**THE PRIMARY OR SECONDARY DIAGNOSIS CODE BILLED DOES NOT MEET THE MEDICAID BILLING REQUIREMENTS FOR THIS PROVIDER TYPE AND SPECIALTY**	**12**	The diagnosis is inconsistent with the provider type. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.

1648	**Invalid or missing first treatment date. Resubmit claim with valid first treatment date**	**125**	Submission-billing error(s)	**MA122**	Missing-incomplete-invalid initial treatment date.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
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
1650	**Recoupment per medical or policy review**	**B5**	Coverage-program guidelines were not met or were exceeded.	**MA67**	Correction to a prior claim	**101**	Claim was processed as adjustment to previous claim

1651	**Component procedure not allowed same day as comprehensive 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.	**454**	Procedure code for services rendered.
1652	**Care plan oversight already paid for this calendar month.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1653	**Care plan oversight for Home Health recipient already paid for this calendar month.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1654	**Care plan oversight for hospice recipient already paid for this calendar month.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1655	**Comprehensive procedure paid. Component procedures will be recouped.**	**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.
1656	**PAYMENT FOR CARE PLAN OVERSIGHT IS INCLUDED IN DIALYSIS COMPOSITE RATE ALREADY PAID FOR THIS CALENDAR MONTH**	**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.	**287**	Medical necessity for service.

1656	**PAYMENT FOR CARE PLAN OVERSIGHT IS INCLUDED IN DIALYSIS COMPOSITE RATE ALREADY PAID FOR THIS CALENDAR MONTH**	**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.
1657	**PAYMENT FOR CARE PLAN OVERSIGHT IS INCLUDED IN DIALYSIS COMPOSITE RATE BILLED SEPARATELY FOR SAME CALENDAR MONTH**	**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.
1657	**PAYMENT FOR CARE PLAN OVERSIGHT IS INCLUDED IN DIALYSIS COMPOSITE RATE BILLED SEPARATELY FOR SAME CALENDAR MONTH**	**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.	**287**	Medical necessity for service.
1658	**16 psychiatric outpatient visits allowed without prior approval**	**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.
1659	**Attending provider types 112, 180 or 181 not allowed with billing provider 074/113**	**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.
1660	**Final amount added to claims payment due to authorized state payout**	**A7**	Presumptive Payment Adjustment	**N45**	Payment based on authorized amount	**631**	Reimbursement Rate

1663	**Prior claim for case management has been paid for this month.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1664	**Service denied. Drug allows 1200 units per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
1664	**Service denied. Drug allows 1200 units per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
1664	**Service denied. Drug allows 1200 units per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
1664	**Service denied. Drug allows 1200 units per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service
1665	**Secondary Thrombectomy code must be billed with a primary procedure**	**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.	**187**	Date(s) of service.
1665	**Secondary Thrombectomy code must be billed with a primary procedure**	**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.	**N19**	Procedure code incidental to primary procedure.	**187**	Date(s) of service.

1665	**Secondary Thrombectomy code must be billed with a primary procedure**	**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.	**259**	Frequency of service.
1665	**Secondary Thrombectomy code must be billed with a primary procedure**	**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.	**N19**	Procedure code incidental to primary procedure.	**259**	Frequency of service.
1665	**Secondary Thrombectomy code must be billed with a primary procedure**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
1665	**Secondary Thrombectomy code must be billed with a primary procedure**	**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.	**N19**	Procedure code incidental to primary procedure.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
1666	**Dermagraft limited to 4 applications totaling 150.00 sq. cm. 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.

1666	**Dermagraft limited to 4 applications totaling 150.00 sq. cm. per day**	**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.
1666	**Dermagraft limited to 4 applications totaling 150.00 sq. cm. 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
1666	**Dermagraft limited to 4 applications totaling 150.00 sq.**	**119**	Benefit maximum for this time period or occurrence has been	**N357**	Time frame requirements between this service-procedure-	**612**	Per Day Limit Amount
					between this service-procedure-		

1674	**Diagnosis billed is not allowed as primary diagnosis**	**125**	Submission-billing error(s)	**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.
1674	**Diagnosis billed is not allowed as primary diagnosis**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**254**	Primary diagnosis code.
1674	**Diagnosis billed is not allowed as primary diagnosis**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**254**	Primary diagnosis code.
1674	**Diagnosis billed is not allowed as primary diagnosis**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code.	**488**	Diagnosis code(s) for the services rendered.
1674	**Diagnosis billed is not allowed as primary diagnosis**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.
1675	**Drug is limited to 240 units per calendar month. Units have been cutback to allowable units for this timeframe**	**119**	Benefit maximum for this time period or occurrence has been reached		**No Mapping Required**	**259**	Frequency of service
1676	**Units cutback. Exceeds the maximum units allowed per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
1676	**Units cutback. Exceeds the maximum units allowed per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
1676	**Units cutback. Exceeds the maximum units allowed per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1676	**Units cutback. Exceeds the maximum units allowed per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
1677	**Service Denied, Exceeds allowed units per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

1677	**Service Denied, Exceeds allowed units per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
1678	**Related aneurysm procedures not allowed on the same date of service.**	**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.
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.
1681	**Related laminotomy procedures not allowed on same date of service.**	**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.
1682	**Vaccine procedure only allowed 2 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.
1682	**Vaccine procedure only allowed 2 per lifetime.**	**149**	Lifetime benefit maximum has been reached for this service-benefit category.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.

1683	**Diabetes self management training services, individual or group sessions not allowed more than 20 units per calendar 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.	**258**	Days-units for procedure-revenue code.
1683	**Diabetes self management training services, individual or group sessions not allowed more than 20 units per calendar year.**	**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.	**258**	Days-units for procedure-revenue code.
					between this service-procedure-		

1685	**The procedure billed requires a modifier which will establish the number of patients served for this DOS. Please check your procedure, correct your claim and resubmit**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**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.
1685	**The procedure billed requires a modifier which will establish the number of patients served for this DOS. Please check your procedure, correct your claim and resubmit**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**N180**	This item or service does not meet the criteria for the category under which it was billed.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1686	**Diabetes self management outpatient service not allowed same day as physician service.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
1686	**Diabetes self management outpatient service not allowed same day as physician service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
1686	**Diabetes self management outpatient service not allowed same day as physician service.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
1686	**Diabetes self management outpatient service not allowed same day as physician service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
1687	**Physician service not allowed same day as diabetes self management outpatient service.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
1687	**Physician service not allowed same day as diabetes self management outpatient service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.

1687	**Physician service not allowed same day as diabetes self management outpatient service.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
1687	**Physician service not allowed same day as diabetes self management outpatient service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
1689	**Condition code indicating Medicare override not allowed when Medicare payment is also indicated on claim**	**125**	Submission-billing error(s)	**M44**	Missing-incomplete-invalid condition code	**460**	NUBC Condition Code(s)
1690	**Related MRI procedures not allowed by the same attending provider.**	**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.
1691	**DMA 3000 PCS PACT is missing, incomplete or invalid. Please attach required information and submit the claim 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.
1691	**DMA 3000 PCS PACT is missing, incomplete or invalid. Please attach required information and submit the claim to DMA program integrity home care review**	**A1**	Claim-Service denied	**N357**	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.

1691	**DMA 3000 PCS PACT is missing, incomplete or invalid. Please attach required information and submit the claim to DMA program integrity home care review**	**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.
1691	**DMA 3000 PCS PACT is missing, incomplete or invalid. Please attach required information and submit the claim to DMA program integrity home care review**	**A1**	Claim-Service denied	**N29**	Missing documentation-orders-notes-summary-report-chart.	**294**	Supporting documentation
1691	**DMA 3000 PCS PACT is missing, incomplete or invalid. Please attach required information and submit the claim to DMA program integrity home care review**	**A1**	Claim-Service denied	**N357**	Program integrity-utilization review decision.	**294**	Supporting documentation
1691	**DMA 3000 PCS PACT is missing, incomplete or invalid. Please attach required information and submit the claim to DMA program integrity home care review**	**A1**	Claim-Service denied	**N225**	Incomplete-invalid 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	**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
1696	**Mammography screening limited to one per 5 years**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1696	**Mammography screening limited to one per 5 years**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.

1696	**Mammography screening limited to one per 5 years**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
1696	**Mammography screening limited to one per 5 years**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**453**	Procedure Code Modifier(s) for Service(s) Rendered
1697	**First treatment date not valid, please resubmit claim with correct first treatment date**	**125**	Submission-billing error(s)	**MA122**	Missing-incomplete-invalid initial treatment date.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1697	**First treatment date not valid, please resubmit claim with correct first treatment date**	**125**	Submission-billing error(s)	**MA122**	Missing-incomplete-invalid initial treatment date.	**192**	Date of first service for current series-symptom-illness.
1698	**Invalid Sterilization consent form on file. Informed consent obtained by DSS**	**125**	Submission-billing error(s)	**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)
1698	**Invalid Sterilization consent form on file. Informed consent obtained by DSS**	**125**	Submission-billing error(s)	**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.
1699	**Service is not consistent with or not covered for this diagnosis or description of service does not match diagnosis**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition	**488**	Diagnosis code(s) for the services rendered
1700	**No Medicare cost share due**	**A1**	Claim-Service denied	**M16**	Alert- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**3**	Claim has been adjudicated and is awaiting payment cycle
1700	**No Medicare cost share due**	**A1**	Claim-Service denied	**N45**	Payment based on authorized amount	**3**	Claim has been adjudicated and is awaiting payment cycle

1700	**No Medicare cost share due**	**A1**	Claim-Service denied	**M16**	Alert- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information
1700	**No Medicare cost share due**	**A1**	Claim-Service denied	**N45**	Payment based on authorized amount	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information
1701	**Recipient was not enrolled in Medicare HMO on date of service**	**A1**	Claim-Service denied	**M16**	Alert- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**3**	Claim has been adjudicated and is awaiting payment cycle
1701	**Recipient was not enrolled in Medicare HMO on date of service**	**A1**	Claim-Service denied	**N382**	Missing-incomplete-invalid patient identifier	**3**	Claim has been adjudicated and is awaiting payment cycle
1701	**Recipient was not enrolled in Medicare HMO on date of service**	**A1**	Claim-Service denied	**M16**	Alert- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information
1701	**Recipient was not enrolled in Medicare HMO on date of service**	**A1**	Claim-Service denied	**N382**	Missing-incomplete-invalid patient identifier	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information
1702	**Medicare Part C cost share previously paid. Adjustment of previously paid cost share amount will appear on future RA**	**A1**	Claim-Service denied	**M16**	Alert- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**3**	Claim has been adjudicated and is awaiting payment cycle
1702	**Medicare Part C cost share previously paid. Adjustment of previously paid cost share amount will appear on future RA**	**A1**	Claim-Service denied	**N45**	Payment based on authorized amount	**3**	Claim has been adjudicated and is awaiting payment cycle

1702	**Medicare Part C cost share previously paid. Adjustment of previously paid cost share amount will appear on future RA**	**A1**	Claim-Service denied	**M16**	Alert- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information
1702	**Medicare Part C cost share previously paid. Adjustment of previously paid cost share amount will appear on future RA**	**A1**	Claim-Service denied	**N45**	Payment based on authorized amount	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information
1706	**Non-Physican Counseling Immunization Administration procedure not allowed same day as Physician Counseling Immunization**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**259**	Frequency of service
1707	**Procedure recouped. Administration with Non-Physician Counseling not allowed same day as Physician Counseling**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**259**	Frequency of service
1709	**Therapeutic foster care/IAFC paid in history**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
1711	**Portable geseous oxygen system; Home compressor including containes not allowed during same period as other related system/units.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
1711	**Portable geseous oxygen system; Home compressor including containes not allowed during same period as other related system/units.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.

1711	**Portable geseous oxygen system; Home compressor including containes not allowed during same period as other related system/units.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
1711	**Portable geseous oxygen system; Home compressor including containes not allowed during same period as other related system/units.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**455**	Revenue code for services rendered.
1711	**Portable geseous oxygen system; Home compressor including containes not allowed during same period as other related system/units.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**455**	Revenue code for services rendered.
1711	**Portable geseous oxygen system; Home compressor including containes not allowed during same period as other related system/units.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**455**	Revenue code for services rendered.
1712	**Other related system/units not allowed when portable gaseous oxygen system; Home compressor including containers is paid in history.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
1712	**Other related system/units not allowed when portable gaseous oxygen system; Home compressor including containers is paid in history.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
1712	**Other related system/units not allowed when portable gaseous oxygen system; Home compressor including containers is paid in history.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.

1712	**Other related system/units not allowed when portable gaseous oxygen system; Home compressor including containers is paid in history.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**455**	Revenue code for services rendered.
1712	**Other related system/units not allowed when portable gaseous oxygen system; Home compressor including containers is paid in history.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**455**	Revenue code for services rendered.
1712	**Other related system/units not allowed when portable gaseous oxygen system; Home compressor including containers is paid in history.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**455**	Revenue code for services rendered.
1713	**Recoup, HIV case management a CAP case management procedure not allowed for the same date of service**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
1716	**Only one early refill per year for lost RX allowed**	**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.
1717	**Early refill due to vacation, restricted to one event (5 day span) per 365 days**	**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.

1718	**CBSA code missing, invalid or does not match zip code of the location where service was provided. Correct claim and refile or contact HP provider services 1-800-688-6696**	**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.
1718	**CBSA code missing, invalid or does not match zip code of the location where service was provided. Correct claim and refile or contact HP provider services 1-800-688-6696**	**125**	Submission-billing error(s)	**M49**	Missing-incomplete-invalid value code(s) or amount(s).	**726**	NUBC Value Code Amount(s)
1718	**CBSA code missing, invalid or does not match zip code of the location where service was provided. Correct claim and refile or contact HP provider services 1-800-688-6696**	**125**	Submission-billing error(s)	**M49**	Missing-incomplete-invalid value code(s) or amount(s).	**500**	Entitys Postal-Zip Code.
1719	**The hospice revenue code billed must be billed with a value code of 61 and corresponding CBSA code.**	**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.
1719	**The hospice revenue code billed must be billed with a value code of 61 and corresponding CBSA code.**	**125**	Submission-billing error(s)	**M49**	Missing-incomplete-invalid value code(s) or amount(s).	**726**	NUBC Value Code Amount(s)
1720	**NDC validity cannot be confirmed**	**125**	Submission-billing error(s)	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number

1721	**Related MRI procedure not allowed on same date of service, same or different provider.**	**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.
1722	**Prior authorization required. Prescriber must call ACS at 1-866-246-8505.**	**197**	Precertification-authorization-notification absent.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**48**	Referral-authorization.
1723	**Non-Preferred agent prescriber must call ACS at 1-866-246-8505.**	**A1**	Claim-Service denied		**No Mapping Required**	**1**	For more detailed information, see remittance advice.
1724	**Secondary Thrombectomy not allowed same day as primary procedure.**	**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.	**187**	Date(s) of service.
1724	**Secondary Thrombectomy not allowed same day as primary procedure.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.

1724	**Secondary Thrombectomy not allowed same day as primary procedure.**	**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.	**259**	Frequency of service.
1724	**Secondary Thrombectomy not allowed same day as primary procedure.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
1725	**Related Mammography screenings not allowed on the same date of service**	**119**	Benefit maximum for this time period or occurrence has been reached	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
1725	**Related Mammography screenings not allowed on the same date of service**	**119**	Benefit maximum for this time period or occurrence has been reached	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
1725	**Related Mammography screenings not allowed on the same date of service**	**119**	Benefit maximum for this time period or occurrence has been reached	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
1725	**Related Mammography screenings not allowed on the same date of service**	**119**	Benefit maximum for this time period or occurrence has been reached	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
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.
1727	**Value code requirements not met. DOS span code requirements. Split claim by DOS & bill MSA code(s) for DOS prior to 01/01/2009 and CBSA code(s) for DOS on or after 01/01/2009.**	**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.
1727	**Value code requirements not met. DOS span code requirements. Split claim by DOS & bill MSA code(s) for DOS prior to 01/01/2009 and CBSA code(s) for DOS on or after 01/01/2009.**	**125**	Submission-billing error(s)	**M49**	Missing-incomplete-invalid value code(s) or amount(s).	**726**	NUBC Value Code Amount(s)
1728	**Sole source diabetic testing supplies now ACCU-CHEK-AVIVA and COMPACT PLUS. For Assistance call 1-877-906-8969**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

1728	**Sole source diabetic testing supplies now ACCU-CHEK-AVIVA and COMPACT PLUS. For Assistance call 1-877-906-8969**	**A1**	Claim-Service denied	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**25**	Entity not approved.
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	**N19**	Procedure code incidental to primary procedure.	**490**	Other Procedure Code for Service(s) Rendered
					between this service-procedure-		

1733	**Service/Billing not allowed after 12/14/2010**	**125**	Submission-billing error(s)	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	**187**	Date(s) of service.
1735	**Prior claim for CAP case management has been paid for this month under a different CAP program**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
1737	**Procedure/Product denied. Product requires use of preferred vendor-prodigy**	**A1**	Claim-Service denied	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1737	**Procedure/Product denied. Product requires use of preferred vendor-prodigy**	**A1**	Claim-Service denied	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**25**	Entity not approved.
1740	**The billing provider is not the controlled substance lock-in provider**	**125**	Submission-billing error(s)	**N32**	Claim must be submitted by the provider who rendered the service.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1740	**The billing provider is not the controlled substance lock-in provider**	**125**	Submission-billing error(s)	**N32**	Claim must be submitted by the provider who rendered the service.	**25**	Entity not approved. This change effective 11-1-2010-Entity not approved. Note- This code requires use of an Entity Code.
1741	**The prescriber is not the controlled substance lock-in prescriber**	**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.
1741	**The prescriber is not the controlled substance lock-in prescriber**	**125**	Submission-billing error(s)	**N31**	Missing-incomplete-invalid prescribing provider identifier.	**25**	Entity not approved. This change effective 11-1-2010-Entity not approved. Note- This code requires use of an Entity Code.

1742	**Only one emergency fill of a conrolled substance allowed per 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.	**259**	Frequency of service.
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	**N381**	Consult our contractual agreement for restrictions-billing information related to these charges.	**454**	Procedure code for services rendered.
							This change effective 7-1-2011-

1748	**Replacement transactions will not be processed for encounters. Please void original encounter ICN and submit correction as a new transaction**	**A1**	Claim-Service denied	**M79**	Missing-incomplete-invalid charge	**21**	Missing or invalid information
1749	**Related fetal biophysical profile procedures not allowed on the same date of service.**	**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.
1750	**Fluoride varnish application must be billed with related procedure codes on the same claim**	**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.	**42**	Awaiting related charges
1750	**Fluoride varnish application must be billed with related procedure codes on the same claim**	**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.	**42**	Awaiting related charges
1751	**Related prostate specific antigen (PSA) procedures not allowed on the same date of service**	**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.

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.
1753	**Vitamin, unspecified not on same date of service as vitamins A or K.**	**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.
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
1756	**Service denied. Recipient and/or the billing provider does not meet the medicaid guidelines required for this service**	**A1**	Claim-Service denied	**N30**	Patient ineligible for this service.	**109**	Entity not eligible. Note- This code requires use of an Entity Code.
1756	**Service denied. Recipient and/or the billing provider does not meet the medicaid guidelines required for this service**	**A1**	Claim-Service denied	**N59**	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.

1758	**This procedure included in a more comprehensive audiometry procedure billed on same date of 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.
1759	**Procedure recouped to allow reimbursement of more comprehensive procedure.**	**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.
1761	**Related CAP service not allowed on same day as CAP-MR-DD institutional respite.**	**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.
1762	**Cap-MR-DD habilitation service not allowed on same date as adult day health.**	**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.

1763	**Cap-MR-DD supported living hourly procedure not allowed on same date as supported living.**	**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.
1764	**CAP-MR-DD group respite and institutional respite are not allowed on the same date of service.**	**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.
1765	**CAP dollar limitation has been exceeded for this service.**	**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.
1766	**Service denied. Drug allows 2000 units per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
1766	**Service denied. Drug allows 2000 units per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code.
1766	**Service denied. Drug allows 2000 units per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service

1766	**Service denied. Drug allows 2000 units per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service
1767	**Units were changed to maximum allowable, limitation has been reached. Submit adjustment with necessary documentation.**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	he number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
1767	**Units were changed to maximum allowable, limitation has been reached. Submit adjustment with necessary documentation.**	**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
1767	**Units were changed to maximum allowable, limitation has been reached. Submit adjustment with necessary documentation.**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	he number of Days or Units of Service exceeds our acceptable maximum.	**294**	Supporting documentation
1767	**Units were changed to maximum allowable, limitation has been reached. Submit adjustment with necessary documentation.**	**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	**294**	Supporting documentation
1768	**Fee adjusted to maximum allowable, limitation has been reached.**	**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.
1769	**No additional payment made for hearing and-or vision service. Payment is included in Health Check reimbursement.**	**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.

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.
1771	**All components were not rendered for this Health Check Screening.**	**95**	Plan procedures not followed	**N78**	The necessary components of the child and teen checkup (EPSDT) were not completed	**107**	Processed according to contract-plan provisions.
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.
1773	**Only one HRI level IV residential procedure 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.
1773	**Only one HRI level IV residential procedure 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
1774	**Services included in Health Check package**	**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.
1775	**Only one HRI level III residential procedure 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.
1775	**Only one HRI level III residential procedure 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

1776	**Related immunization procedures not allowed on the 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.
1777	**HRI level II group home not allowed with level II therapeutic foster care.**	**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.
1778	**Immunization update and Health Check screen not allowed on the same day by same or different Health Department.**	**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.
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.
1780	**Therapeutic leave quarterly limit exceeded**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
1781	**The RX clarification code specified is not valid for the recipient and drug. Only Long-Term Care recipients are valid for this override.**	**177**	Patient has not met the required eligibility requirements.	**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.

1781	**The RX clarification code specified is not valid for the recipient and drug. Only Long-Term Care recipients are valid for this override.**	**177**	Patient has not met the required eligibility requirements.	**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.	**91**	Entity not eligible-not approved for dates 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.
1783	**MCO Encounter - billed amount invalid**	**A1**	Claim-Service denied	**M79**	Missing-incomplete-invalid charge	**18**	Entity received claim-encounter, but returned invalid status
1783	**MCO Encounter - billed amount invalid**	**A1**	Claim-Service denied	**M79**	Missing-incomplete-invalid charge	**21**	Missing or invalid information
1784	**Service denied. An ultrasound has already been paid for this date of 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1785	**MCO Encounter - invalid units**	**A1**	Claim-Service denied	**M53**	Missing-incomplete-invalid days or units of service.	**18**	Entity received claim-encounter, but returned invalid status
1785	**MCO Encounter - invalid units**	**A1**	Claim-Service denied	**M53**	Missing-incomplete-invalid days or units of service.	**21**	Missing or invalid information
1786	**Please resubmit as an adjustment with medical records supporting units billed.**	**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.	**259**	Frequency of service.

1786	**Please resubmit as an adjustment with medical records supporting units billed.**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**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.	**259**	Frequency of service.
1787	**MCO Encounter - Recipient resides in a county that is not serviced by the MCO**	**A1**	Claim-Service denied	**N79**	Service billed is not compatible with patient location information	**25**	Entity not approved
1788	**One follow-up ultrasound allowed per day. If more than one fetus, please resubmit procedure code with appropriate modifier and diagnosis to support additional unit(s)**	**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.
1788	**One follow-up ultrasound allowed per day. If more than one fetus, please resubmit procedure code with appropriate modifier and diagnosis to support additional unit(s)**	**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
1789	**One OB transvaginal ultrasound allowed per date of service**	**119**	Benefit maximum for this time period or occurrence has been reache	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1789	**One OB transvaginal ultrasound allowed per date of service**	**119**	Benefit maximum for this time period or occurrence has been reache	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
1791	**The attending provider is not associated with the CABHA billing provider for the dates of service billed.**	**125**	Submission-billing error(s)	**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.
1791	**The attending provider is not associated with the CABHA billing provider for the dates of service billed.**	**125**	Submission-billing error(s)	**N253**	Missing-incomplete-invalid attending provider primary identifier.	**562**	Entitys National Provider Identifier (NPI). Note- This code requires use of an Entity Code.

1793	**No payment allowed if "primary" code is not paid in the past 30 day history, same or different provider**	**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	**454**	Procedure code for services rendered
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 reache	**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 reache	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
1795	**Previously paid technical component recouped, complete procedure paid**	**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 (Plan refers to provisions that exist between the Health Plan and the Consumer or Patient)
1796	**MCO Encounter - Claim does not pass all edits**	**A1**	Claim-Service denied	**N380**	The original claim has been processed, submit a corrected claim	**19**	Entity acknowledges receipt of claim-encounter
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.
					between this service-procedure-		

1802	**Service Provider ID is invalid.**	**A1**	Claim-Service denied	**N277**	Missing-incomplete-invalid other payer rendering provider identifier	**562**	Entitys National Provider Identifier (NPI)
1803	**Service no longer covered by Medicaid for recipients who are also enrolled with Medicare**	**22**	This care may be covered by another payer per coordination of benefits.	**N196**	**Alert-** Patient eligible to apply for other coverage which may be primary	**116**	Claim submitted to incorrect payer
1804	**Admit date is prior to program coverage date.**	**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.
1805	**Claim denied for recipient 21 years of age or older with invalid diagnosis.**	**9**	The diagnosis is inconsistent with the patients age.	**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.
1805	**Claim denied for recipient 21 years of age or older with invalid diagnosis.**	**9**	The diagnosis is inconsistent with the patients age.	**M76**	Missing-incomplete-invalid diagnosis or condition.	**255**	Diagnosis code.
1806	**Invalid condition code. Resubmit claim with a valid condition code**	**125**	Submission-billing error(s)	**M44**	Missing-incomplete-invalid condition code	**431**	Provide condition-functional status at time of service.
1806	**Invalid condition code. Resubmit claim with a valid condition code**	**125**	Submission-billing error(s)	**M44**	Missing-incomplete-invalid condition code	**460**	NUBC Condition Code(s).
1808	**UB information/code is invalid. Check admit type, patient status, condition, value or occurrence code(s), correct & resubmit if applicable.**	**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.
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 Homce 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 Homce 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 Homce 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 Homce Care**	**A1**	Claim-Service denied	**N225**	Incomplete-invalid documentation-orders-notes-summary-report-chart.	**294**	Supporting documentation
1811	**Reimbursement for this service has been denied due to the lack of proper service endorsement or medicaid participation.**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**631**	Reimbursement Rate
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**	Entitys 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**	Entitys 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**	Entitys 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**	Entitys National Provider Identifier (NPI). Note- This code requires use of an Entity Code.
1816	**Room and board is not allowed on the same claim as therapeutic leave. Separate services and re-bill**	**A1**	Claim-Service denied	**N61**	Rebill services on separate claims.	**103**	Claim combined with other claim(s).
1817	**Second approach procedure reduced 50% of allowed amount if performed on the same day.**	**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.
1817	**Second approach procedure reduced 50% of allowed amount if performed on the same day.**	**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

1818	**Second repair-reconstruction code for skull base surgery reduced 50% of allowed amount if performed on the same day.**	**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.
1818	**Second repair-reconstruction code for skull base surgery reduced 50% of allowed amount if performed on the same day.**	**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
1819	**Second definitive procedure code reduced 50% of the allowable if performed on the same day.**	**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.
1819	**Second definitive procedure code reduced 50% of the allowable if performed on the same day.**	**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
1820	**Only one vagotomy 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.

1820	**Only one vagotomy 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
1821	**Only one gastrectomy 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.
1821	**Only one gastrectomy 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
1822	**Medicaid has paid the maximum allowable for this equipment code.**	**108**	Rent-purchase guidelines were not met. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M76**	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.	**65**	Claim-line has been paid.
1822	**Medicaid has paid the maximum allowable for this equipment code.**	**108**	Rent-purchase guidelines were not met. 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.
1822	**Medicaid has paid the maximum allowable for this equipment code.**	**108**	Rent-purchase guidelines were not met. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M76**	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.	**186**	Purchase and rental price of durable medical equipment
1822	**Medicaid has paid the maximum allowable for this equipment code.**	**108**	Rent-purchase guidelines were not met. 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	**186**	Purchase and rental price of durable medical equipment

1823	**Payment reduced to equal the purchased new price for each unit allowed Medicaid has previously paid for the equipment code.**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	**M76**	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price	**184**	Purchase price for the rented durable medical equipment.
1824	**The comprehensive metabolic panel includes the basic metabolic & hepatic function panels. Reimbursement is based on CPT 80053.**	**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.
1828	**One override allowed. Sole source diabetic testing supplies now ACCU-CHEK-AVIVA and COMPACT PLUS. For assistance call 1-877-906-8969**	**A1**	Claim-Service denied	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1828	**One override allowed. Sole source diabetic testing supplies now ACCU-CHEK-AVIVA and COMPACT PLUS. For assistance call 1-877-906-8969**	**A1**	Claim-Service denied	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**25**	Entity not approved.
1829	**Repair codes billed in conjunction with a space maintainer are paid at the secondary maximum allowed rate.**	**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.
1830	**Carolina access II enhanced care management fee is reimbursed only through system generated claims.**	**125**	Submission-billing error(s)	**N185**	**Alert-** Do not resubmit this claim-service	**107**	Processed according to contract-plan provisions.

1830	**Carolina access II enhanced care management fee is reimbursed only through system generated claims.**	**125**	Submission-billing error(s)	**N185**	**Alert-** Do not resubmit this claim-service	**585**	Denied Charge or Non-covered Charge.
1833	**Case management not allowed same date of service as case management provided by the CAP program**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service
1834	**Jejunostomy allowed once per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1834	**Jejunostomy allowed once per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
1835	**Service recouped. Jejunostomy previously paid for the same date of service.**	**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.
1838	**NDC missing. The procedure/product billed requires a valid NDC. Sole source diabetic testing supplies now ACCU-CHEK-AVIVA and COMPACT PLUS. For assistance call 1-877-906-8969**	**A1**	Claim-Service denied	**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.

1838	**NDC missing. The procedure/product billed requires a valid NDC. Sole source diabetic testing supplies now ACCU-CHEK-AVIVA and COMPACT PLUS. For assistance call 1-877-906-8969**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number
1839	**Invalid NDC submitted. Resubmit with valid NDC. Sole source diabetic testing supplies now ACCU-CHEK-AVIVA and COMPACT PLUS. For assistance call 1-877-906-8969**	**A1**	Claim-Service denied	**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.
1839	**Invalid NDC submitted. Resubmit with valid NDC. Sole source diabetic testing supplies now ACCU-CHEK-AVIVA and COMPACT PLUS. For assistance call 1-877-906-8969**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number
1840	**NDC submitted not appropriate for product billed. Sole source diabetic testing supplies now ACCU-CHEK-AVIVA and COMPACT PLUS. For assistance call 1-877-906-8969**	**A1**	Claim-Service denied	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1840	**NDC submitted not appropriate for product billed. Sole source diabetic testing supplies now ACCU-CHEK-AVIVA and COMPACT PLUS. For assistance call 1-877-906-8969**	**A1**	Claim-Service denied	**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.

1840	**NDC submitted not appropriate for product billed. Sole source diabetic testing supplies now ACCU-CHEK-AVIVA and COMPACT PLUS. For assistance call 1-877-906-8969**	**A1**	Claim-Service denied	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**218**	NDC number
1840	**NDC submitted not appropriate for product billed. Sole source diabetic testing supplies now ACCU-CHEK-AVIVA and COMPACT PLUS. For assistance call 1-877-906-8969**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number
1841	**NDC submitted for product is not allowed. Sole source diabetic testing supplies now ACCU-CHEK-AVIVA and COMPACT PLUS. For assistance call 1-877-906-8969**	**A1**	Claim-Service denied	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1841	**NDC submitted for product is not allowed. Sole source diabetic testing supplies now ACCU-CHEK-AVIVA and COMPACT PLUS. For assistance call 1-877-906-8969**	**A1**	Claim-Service denied	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**25**	Entity not approved.
1842	**Bill type submitted requires appropriate external cause diagnosis. External cause diagnosis is missing or invalid. Correct claim and resubmit**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**228**	Type of bill for UB claim
1844	**Claims payment is not allowed for SCHIP/NC Health Choice recipients for the submitted diagnosis**	**A1**	Claim-Service denied	**N30**	Patient ineligible for this service	**255**	Diagnosis code

1845	**The Billing provider is not allowed for this service on or after the date of service billed**	**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.	**N185**	**Alert-** Do not resubmit this claim-service.	**91**	Entity not eligible-not approved for dates of service. Note- This code requires use of an Entity Code.
1846	**Home health service recouped. PDN service paid/allowed for this date of service**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
1847	**Claim denied. Exceeds the allowable 100 Medicaid units per 84 day 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.	**258**	Days-units for procedure-revenue code.
1847	**Claim denied. Exceeds the allowable 100 Medicaid units per 84 day period**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code.
1847	**Claim denied. Exceeds the allowable 100 Medicaid units per 84 day 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
1847	**Claim denied. Exceeds the allowable 100 Medicaid units per 84 day period**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service
1848	**The submitted bill type is inappropriate for the external cause diagnosis billed. Correct the bill type or evaluate external cause diagnosis for correction and resubmit**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**228**	Type of bill for UB claim

1849	**NEVER EVENT, PAID $0.00**	**50**	These are non-covered services because this is not deemed a medical necessity by the payer. 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.	**N180**	This item or service does not meet the criteria for the category under which it was billed.	**287**	Medical necessity for service.
1850	**CABHA provider does not meet enrollment criteria**	**A1**	Claim-Service denied	**N36**	Claim must meet primary payers processing requirements before we can consider payment.	**275**	Claim
1850	**CABHA provider does not meet enrollment criteria**	**A1**	Claim-Service denied	**N59**	Please refer to your provider manual for additional program and provider information.	**275**	Claim
1850	**CABHA provider does not meet enrollment criteria**	**A1**	Claim-Service denied	**N130**	Consult plan benefit documents-guidelines for information about restrictions for this service.	**275**	Claim
1851	**Only two psych visits allowed per day for provisionally licensed services.**	**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.
1851	**Only two psych visits allowed per day for provisionally licensed services.**	**119**	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.
1851	**Only two psych visits allowed per day for provisionally licensed services.**	**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
1851	**Only two psych visits allowed per day for provisionally licensed services.**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount

1853	**Units cutback to allow the maximum of 2 units per day**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
1853	**Units cutback to allow the maximum of 2 units per day**	**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.
1853	**Units cutback to allow the maximum of 2 units per day**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
1853	**Units cutback to allow the maximum of 2 units per day**	**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.
1853	**Units cutback to allow the maximum of 2 units per day**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**476**	Missing or invalid units of service
1853	**Units cutback to allow the maximum of 2 units per day**	**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.	**476**	Missing or invalid units of service
1860	**OPT must be billed with verteporfin, verteporfin must be also be billed with OPT.**	**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	**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.
1861	**Exceeds 10 treatments of OPT per 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.	**259**	Frequency of service.
1862	**Add on code for concurrent eye must be billed with primary code for OPT.**	**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.	**454**	Procedure code for services rendered.

1862	**Add on code for concurrent eye must be billed with primary code for OPT.**	**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	**N161**	This drug-service-supply is covered only when the associated service is covered.	**454**	Procedure code for services rendered.
					between this service-procedure-		

1864	**Only 3 units allowed per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
1864	**Only 3 units allowed per date of service.**	**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.	**612**	Per Day Limit Amount
1864	**Only 3 units allowed per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount
1865	**Dollar amount cutback to maximum allowable for this service, for this period of time**	**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.
1866	**Physician stand-by service exceeds 2 hour limit. if necessary, correct denied detail and resubmit as a new claim.**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**259**	Frequency of service.
1867	**NICU codes allowed once per day. NICU already paid for 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.
1867	**NICU codes allowed once per day. NICU already paid for this date of service.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
1868	**Prolonged services exceeds 3 hour maximum allowed per day for all providers. if necessary, correct the number in units field and resubmit as a new claim.**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**259**	Frequency of service.
1868	**Prolonged services exceeds 3 hour maximum allowed per day for all providers. if necessary, correct the number in units field and resubmit as a new claim.**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**612**	Per Day Limit Amount

1869	**Only one esophagectomy procedure 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.
1869	**Only one esophagectomy**	**119**	Benefit maximum for this time period or occurrence has been	**M86**	Service denied because payment already made for	**612**	Per Day Limit Amount
	Correct all units-details on claim-						

1871	**1 Ambulance base can be billed for same DOS, same hour-time. Correct all units-details on claim-resubmit. Multi respondents-single transport exception file adjustment w-records.**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**N29**	Missing documentation-orders-notes- summary- report- chart	**428**	Reason for transport by ambulance.
1872	**Alcohol-drug intensive outpatient services not allowed during inpatient stay**	**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.
1873	**Immunization administration limit is two per date of service. If billing multiple units on a single detail, correct units on CMS 1500 and resubmit**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**259**	Frequency of service.
1873	**Immunization administration limit is two per date of service. If billing multiple units on a single detail, correct units on CMS 1500 and resubmit**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**612**	Per Day Limit Amount
1874	**Only one ambulance miles and-or base can be billed for the same DOS, same hour-time of pick up. file an adjustment with records for multi respondents, single transport exceptions.**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**N29**	Missing documentation-orders-notes- summary- report- chart	**428**	Reason for transport by ambulance
1875	**Client behavior intervention limited to 32 units (8 hours) 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.

1875	**Client behavior intervention limited to 32 units (8 hours) per**	**119**	Benefit maximum for this time period or occurrence has been	**N357**	Time frame requirements between this service-procedure-	**259**	Frequency of service.
					between this service-procedure-		

1882	**Units cut back. Please resubmit as an adjustment with anesthesia records to support additional units.**	**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	**N203**	Missing-incomplete-invalid anesthesia time-units	**258**	Days-units for procedure-revenue code.
1882	**Units cut back. Please resubmit as an adjustment with anesthesia records to support additional units.**	**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	**N203**	Missing-incomplete-invalid anesthesia time-units	**476**	Missing or invalid units of service
1882	**Units cut back. Please resubmit as an adjustment with anesthesia records to support additional units.**	**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	**N203**	Missing-incomplete-invalid anesthesia time-units	**522**	Anesthesia Modifying Units
1883	**Cesarean delivery paid in history. File an adjustment of previously paid claim and rebill using appropriate OB anesthesia procedure code for cesarean-hysterectomy**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
1884	**Service denied. Anesthesia vaginal delivery and cesarean delivery not allowed same date of service.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.

1885	**Service denied. Anesthesia vaginal delivery and cesarean delivery not allowed same date of service.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
1886	**Service denied. Neuraxial labor anesthesia-analgesia is limited to one unit of service.**	**A1**	Claim-Service denied	**M53**	Missing-incomplete-invalid days or units of service.	**476**	Missing or invalid units of service
1886	**Service denied. Neuraxial labor anesthesia-analgesia is limited to one unit of service.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**476**	Missing or invalid units of service
1887	**Combine charges and rebill using major anesthesia code. Indicate total time (units) in column G. File adjustment of previously paid claim if necessary.**	**A1**	Claim-Service denied	**M51**	Missing-incomplete-invalid procedure code(s).	**258**	Days-units for procedure-revenue code.
1887	**Combine charges and rebill using major anesthesia code. Indicate total time (units) in column G. File adjustment of previously paid claim if necessary.**	**A1**	Claim-Service denied	**N203**	Missing-incomplete-invalid anesthesia time-units	**258**	Days-units for procedure-revenue code.
1887	**Combine charges and rebill using major anesthesia code. Indicate total time (units) in column G. File adjustment of previously paid claim if necessary.**	**A1**	Claim-Service denied	**M51**	Missing-incomplete-invalid procedure code(s).	**454**	Procedure code for services rendered.
1887	**Combine charges and rebill using major anesthesia code. Indicate total time (units) in column G. File adjustment of previously paid claim if necessary.**	**A1**	Claim-Service denied	**N203**	Missing-incomplete-invalid anesthesia time-units	**454**	Procedure code for services rendered.

1887	**Combine charges and rebill using major anesthesia code. Indicate total time (units) in column G. File adjustment of previously paid claim if necessary.**	**A1**	Claim-Service denied	**M51**	Missing-incomplete-invalid procedure code(s).	**523**	Anesthesia Unit Count
1887	**Combine charges and rebill using major anesthesia code. Indicate total time (units) in column G. File adjustment of previously paid claim if necessary.**	**A1**	Claim-Service denied	**N203**	Missing-incomplete-invalid anesthesia time-units	**523**	Anesthesia Unit Count
1888	**One anesthesia procedure allowed per same date of service.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
1892	**DME handrim projections limited to two per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1892	**DME handrim projections limited to two per date of service.**	**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.
1892	**DME handrim projections limited to two per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
1892	**DME handrim projections limited to two per date of service.**	**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	**612**	Per Day Limit Amount

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	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
					between this service-procedure-		

1898	**Units cutback. Maximum number of units per year exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service
					between this service-procedure-		

1902	**DME leg straps limited to one**	**119**	Benefit maximum for this time	**M86**	Service denied because	**612**	Per Day Limit Amount
					between this service-procedure-		

1904	**DME heel loops limited to two**	**119**	Benefit maximum for this time	**N357**	Time frame requirements	**612**	Per Day Limit Amount
					between this service-procedure-		

1907	**DME handrims limited to two**	**119**	Benefit maximum for this time	**M86**	Service denied because	**259**	Frequency of service
					between this service-procedure-		

1909	**DME back insert limited to one**	**119**	Benefit maximum for this time	**N357**	Time frame requirements	**259**	Frequency of service
					between this service-procedure-		

1911	**DME caster tires limited to two**	**119**	Benefit maximum for this time	**M86**	Service denied because	**612**	Per Day Limit Amount
					between this service-procedure-		

1913	**DME footrests limited to two per date of service.**	**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	**612**	Per Day Limit Amount
					between this service-procedure-		

1916	**DME equipment allowed twice in 2 yrs for ages 00-20.**	**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
1916	**DME equipment allowed twice in 2 yrs for ages 00-20.**	**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
1917	**DME equipment allowed once in 3 yrs for ages 21-99.**	**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
1917	**DME equipment allowed once in 3 yrs for ages 21-99.**	**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
1918	**Health Check Screening and original Core Visit not allowed same day by same or different provider. Original Core Visit denied.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
1918	**Health Check Screening and original Core Visit not allowed same day by same or different provider. Original Core Visit denied.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
1918	**Health Check Screening and original Core Visit not allowed same day by same or different provider. Original Core Visit denied.**	**A1**	Claim-Service denied	**N130**	Consult plan benefit documents-guidelines for information about restrictions for this service.	**187**	Date(s) of service.
1918	**Health Check Screening and original Core Visit not allowed same day by same or different provider. Original Core Visit denied.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
1918	**Health Check Screening and original Core Visit not allowed same day by same or different provider. Original Core Visit denied.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.

1918	**Health Check Screening and original Core Visit not allowed same day by same or different provider. Original Core Visit denied.**	**A1**	Claim-Service denied	**N130**	Consult plan benefit documents-guidelines for information about restrictions for this service.	**454**	Procedure code for services rendered.
1919	**DME equipment allowed once in 3 yrs for ages 21-99.**	**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
1919	**DME equipment allowed once in 3 yrs for ages 21-99.**	**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
1920	**Personal care not allowed on same day as CAP - MR-DD supported living**	**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.
1921	**Personal care services not allowed on same day as Adult Care Home personal care service**	**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.

1922	**Personal care services not allowed same day as CAP In-home aide**	**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.
1923	**Personal care services not allowed same day as CAP attendant care services**	**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.
1924	**Personal care services not allowed same day as Hospice**	**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.

1925	**Related services not allowed on same date of service**	**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.
1926	**Personal care service not allowed same day as Home Health Aide service**	**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.
1927	**PDN not allowed same day as HRI-RI facility**	**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.

1928	**PDN recouped if billed the same date of service as HRI-RI**	**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.
1930	**Service billed is not valid for the recipient's age**	**A1**	Claim-Service denied	**N130**	Consult plan benefit documents-guidelines for information about restrictions for this service.	**453**	Procedure code modifier(s) for service(s) rendered.
1930	**Service billed is not valid for the recipient's age**	**A1**	Claim-Service denied	**N519**	Invalid combination of HCPCS modifiers.	**453**	Procedure code modifer(s) for service(s) rendered.
1932	**Family planning should not be indicated.**	**150**	Payer deems the information submitted does not support this level of service		**No Mapping Required**	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1932	**Family planning should not be indicated.**	**150**	Payer deems the information submitted does not support this level of service		**No Mapping Required**	**568**	Family Planning Indicator
1938	**Original core visit recouped. Original core visit not allowed same day as Health Check Screening same or different provider.**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
1938	**Original core visit recouped. Original core visit not allowed same day as Health Check Screening same or different provider.**	**169**	Alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
1938	**Original core visit recouped. Original core visit not allowed same day as Health Check Screening same or different provider.**	**169**	Alternate benefit has been provided.	**N130**	Consult plan benefit documents-guidelines for information about restrictions for this service.	**187**	Date(s) of service.

1938	**Original core visit recouped. Original core visit not allowed same day as Health Check Screening same or different provider.**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
1938	**Original core visit recouped. Original core visit not allowed same day as Health Check Screening same or different provider.**	**169**	Alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
1938	**Original core visit recouped. Original core visit not allowed same day as Health Check Screening same or different provider.**	**169**	Alternate benefit has been provided.	**N130**	Consult plan benefit documents-guidelines for information about restrictions for this service.	**454**	Procedure code for services rendered.
1942	**NDC is no longer covered due to NDC is obsolete.**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**77**	Discontinued Product/Service ID Number	**457**	Non-Covered Day(s)
1943	**Only 2 tablets-units are allowed per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1943	**Only 2 tablets-units are allowed per calendar month.**	**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.
1943	**Only 2 tablets-units are allowed per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
1944	**CPT code 90782 for therapeutic or diagnostic injection must be billed with the evocative-suppression testing codes as listed in CPT. Use HCPC codes for other injection.**	**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.	**454**	Procedure code for services rendered.

1944	**CPT code 90782 for therapeutic or diagnostic injection must be billed with the evocative-suppression testing codes as listed in CPT. Use HCPC codes for other injection.**	**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.	**454**	Procedure code for services rendered.
1946	**Service Denied, receiving PDN services on the same date of service.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
1946	**Service Denied, receiving PDN services on the same date of service.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
1946	**Service Denied, receiving PDN services on the same date of service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
1946	**Service Denied, receiving PDN services on the same date of service.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**585**	Denied Charge or Non-covered Charge
1946	**Service Denied, receiving PDN services on the same date of service.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
1946	**Service Denied, receiving PDN services on the same date of service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**585**	Denied Charge or Non-covered Charge
1947	**Immunization administration denied. No indication that vaccines were administered for this date.**	**112**	Service not furnished directly to the patient and-or not documented.		**No Mapping Required**	**187**	Date(s) of service.

1949	**Incorrect combination of HCPC codes. Refer to the December 2002 or the September 2003 Medicaid bulletin for billing instructions.**	**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.
1950	**Medicaid has paid maximum allowable for this equipment code.**	**108**	Rent-purchase guidelines were not met. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M7**	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.	**186**	Purchase and rental price of durable medical equipment
1950	**Medicaid has paid maximum allowable for this equipment code.**	**108**	Rent-purchase guidelines were not met. 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	**186**	Purchase and rental price of durable medical equipment
1951	**Medicaid has paid maximum allowable for this equipment code.**	**108**	Rent-purchase guidelines were not met. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M7**	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.	**186**	Purchase and rental price of durable medical equipment
1951	**Medicaid has paid maximum allowable for this equipment code.**	**108**	Rent-purchase guidelines were not met. 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	**186**	Purchase and rental price of durable medical equipment
1952	**Payment reduced to equal new purchase price. Medicaid has previously paid for this equipment code.**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	**M7**	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price	**184**	Purchase price for the rented durable medical equipment.
1953	**Payment reduced to equal new purchase price. Medicaid has previously paid for this equipment code.**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	**M7**	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price	**184**	Purchase price for the rented durable medical equipment.

1954	**Recipient claim covered under Hospice**	**B9**	Patient is enrolled in a Hospice	**N30**	Patient ineligible for this service.	**91**	Entity not eligible-not approved for dates of service.
1955	**FluMist not allowed same date of service as administration procedures**	**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.
1956	**Duplicate service denied. If multiple details of the same procedure were billed, combine units on a single detail and resubmit as a new claim.**	**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.
1957	**FluMist obtained thru the VFC program not allowed same DOS as purchased FluMist**	**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.
1958	**DAW not allowed with Family Planning Waiver**	**A1**	Claim-Service denied		**No Mapping Required**	**107**	Processed according to contract-plan provisions.
1958	**DAW not allowed with Family Planning Waiver**	**A1**	Claim-Service denied		**No Mapping Required**	**454**	Procedure code for services rendered.
1961	**CAP limitation has been 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.
1961	**CAP limitation has been 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.

1961	**CAP limitation has been exceeded.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
1961	**CAP limitation has been 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	**483**	Maximum coverage amount met or exceeded for benefit period.
1962	**Service denied. Exceeds the maximum units allowed per day**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
1962	**Service denied. Exceeds the maximum units allowed per day**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
1962	**Service denied. Exceeds the maximum units allowed per day**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
1964	**Service is not consistent with or not covered for this diagnosis or description of service does not match diagnosis**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition	**488**	Diagnosis code(s) for the services rendered
1965	**Service denied. Drug allows 100 units 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.
1965	**Service denied. Drug allows 100 units per day**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount
1967	**Multiple procedure-modifiers not allowed same day by same or different provider**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
1967	**Multiple procedure-modifiers not allowed same day by same or different provider**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.

1967	**Multiple procedure-modifiers not allowed same day by same or different provider**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
1967	**Multiple procedure-modifiers not allowed same day by same or different provider**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
1967	**Multiple procedure-modifiers not allowed same day by same or different provider**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1967	**Multiple procedure-modifiers not allowed same day by same or different provider**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
1967	**Multiple procedure-modifiers not allowed same day by same or different 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
1967	**Multiple procedure-modifiers not allowed same day by same or different provider**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
1967	**Multiple procedure-modifiers not allowed same day by same or different 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
1968	**Fitting of contact lens must be billed with appropriate contact lens code**	**A1**	Claim-Service denied	**M51**	Missing-incomplete-invalid procedure code(s)	**454**	Procedure code for services rendered
1969	**Repairs of AAC device cannot exceed $500 per recipient annually.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N171**	Payment for repair or replacement is not covered or has exceeded the purchase price.	**186**	Purchase and rental price of durable medical equipment.
1969	**Repairs of AAC device cannot exceed $500 per recipient annually.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N435**	Exceeds number-frequency approved -allowed within time period without support documentation.	**186**	Purchase and rental price of durable medical equipment.

1969	**Repairs of AAC device cannot exceed $500 per recipient annually.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N171**	Payment for repair or replacement is not covered or has exceeded the purchase price.	**483**	Maximum coverage amount met or exceeded for benefit period.
1969	**Repairs of AAC device cannot exceed $500 per recipient annually.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N435**	Exceeds number-frequency approved -allowed within time period without support documentation.	**483**	Maximum coverage amount met or exceeded for benefit period.
1970	**Only one Telemedicine occurrence allowed per day**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
1970	**Only one Telemedicine occurrence allowed per day**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
1970	**Only one Telemedicine occurrence allowed per day**	**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.
1970	**Only one Telemedicine occurrence allowed per day**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N20**	Service not payable with other service rendered on the same date.	**612**	Per Day Limit Amount
1970	**Only one Telemedicine occurrence allowed per day**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**612**	Per Day Limit Amount
1970	**Only one Telemedicine occurrence allowed per day**	**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	**612**	Per Day Limit Amount
1971	**Only three Telemedicine occurrences allowed per day**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**259**	Frequency of service.
1971	**Only three Telemedicine occurrences allowed per day**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**612**	Per Day Limit Amount

1972	**Only one Telehealth site service allowed per day same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	259 - Frequency of service.
1972	**Only one Telehealth site service allowed per day same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time	**259**	Frequency of service.
1972	**Only one Telehealth site service allowed per day same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**612**	Per Day Limit Amount
1972	**Only one Telehealth site service allowed per day same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time	**612**	Per Day Limit Amount
1973	**Service denied. Vaginal delivery included with postpartum care.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
1973	**Service denied. Vaginal delivery included with postpartum care.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
1973	**Service denied. Vaginal delivery included with postpartum care.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**585**	Denied Charge or Non-covered Charge
1973	**Service denied. Vaginal delivery included with postpartum care.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
1974	**AAC Device, Software, Upgrades, Mounting System, Accessories and Repairs for one recipient not to exceed $9,500 for a two-year period.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N171**	Payment for repair or replacement is not covered or has exceeded the purchase price.	**186**	Purchase and rental price of durable medical equipment.

1974	**AAC Device, Software, Upgrades, Mounting System, Accessories and Repairs for one recipient not to exceed $9,500 for a two-year period.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N435**	Exceeds number-frequency approved -allowed within time period without support documentation.	**186**	Purchase and rental price of durable medical equipment.
1974	**AAC Device, Software, Upgrades, Mounting System, Accessories and Repairs for one recipient not to exceed $9,500 for a two-year period.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N171**	Payment for repair or replacement is not covered or has exceeded the purchase price.	**483**	Maximum coverage amount met or exceeded for benefit period.
1974	**AAC Device, Software, Upgrades, Mounting System, Accessories and Repairs for one recipient not to exceed $9,500 for a two-year period.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N435**	Exceeds number-frequency approved -allowed within time period without support documentation.	**483**	Maximum coverage amount met or exceeded for benefit period.
1975	**Qualifying circumstance procedure requires related anesthesia procedure to be paid in history.**	**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	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**454**	Procedure code for services rendered.
1975	**Qualifying circumstance procedure requires related anesthesia procedure to be paid in history.**	**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	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	**454**	Procedure code for services rendered.
1976	**The zip code applied I your service location field is missing or invalid. Zip code must be entered and compatible with the CBSA code applied to your 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.

1976	**The zip code applied I your service location field is missing or invalid. Zip code must be entered and compatible with the CBSA code applied to your claim.**	**125**	Submission-billing error(s)	**M49**	Missing-incomplete-invalid value code(s) or amount(s).	**726**	NUBC Value Code Amount(s)
1976	**The zip code applied I your service location field is missing or invalid. Zip code must be entered and compatible with the CBSA code applied to your claim.**	**125**	Submission-billing error(s)	**M49**	Missing-incomplete-invalid value code(s) or amount(s).	**500**	Entitys Postal-Zip Code
1977	**CRNA required to bill with appropriate modifier.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**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.
1977	**CRNA required to bill with appropriate modifier.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
1978	**Service recouped. CRNA required to bill appropriate modifier.**	**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.
1979	**DME equipment accessory allowed once every 182 days, ages 000-020.**	**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.

1979	**DME equipment accessory allowed once every 182 days, ages 000-020.**	**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.
1980	**DME equipment allowed 3 units per 2 years**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1980	**DME equipment allowed 3 units per 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.
1981	**Related splenectomy procedures not allowed same date of service.**	**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.
1982	**Service recouped. Splenectomy previously paid as complete procedure**	**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.
1983	**DME equipment allowed 6 units per 2 years.**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
1983	**DME equipment allowed 6 units per 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

1984	**Service Denied. Postpartum included with vaginal delivery**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
1984	**Service Denied. Postpartum included with vaginal delivery**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
1984	**Service Denied. Postpartum included with vaginal delivery**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**585**	Denied Charge or Non-covered Charge
1984	**Service Denied. Postpartum included with vaginal delivery**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
1985	**Service denied. Procedure unit limitation exceeded**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
1985	**Service denied. Procedure unit limitation exceeded**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
1985	**Service denied. Procedure unit limitation exceeded**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
1985	**Service denied. Procedure unit limitation exceeded**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**454**	Procedure code for services rendered.
1985	**Service denied. Procedure unit limitation exceeded**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
1985	**Service denied. Procedure unit limitation exceeded**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount

1990	**Component of x-ray (either technical or professional) denied. Same procedure has already been reimbursed as complete procedure within a year. Same or different provider**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
1990	**Component of x-ray (either technical or professional) denied. Same procedure has already been reimbursed as complete procedure within a year. Same or different provider**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**259**	Frequency of service
1990	**Component of x-ray (either technical or professional) denied. Same procedure has already been reimbursed as complete procedure within a year. Same or different provider**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**259**	Frequency of service
1990	**Component of x-ray (either technical or professional) denied. Same procedure has already been reimbursed as complete procedure within a year. Same or different provider**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**318**	X-rays
1990	**Component of x-ray (either technical or professional) denied. Same procedure has already been reimbursed as complete procedure within a year. Same or different provider**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**318**	X-rays
1990	**Component of x-ray (either technical or professional) denied. Same procedure has already been reimbursed as complete procedure within a year. Same or different provider**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**318**	X-rays

1991	**Complete x-ray procedure denied. Technical component of this procedure has been reimbursed within a year, same or different provider. Rebill for professional component only.**	**A1**	Claim-Service denied	**N13**	Payment based on professional technical component modifier(s).	**259**	Frequency of service
1991	**Complete x-ray procedure denied. Technical component of this procedure has been reimbursed within a year, same or different provider. Rebill for professional component only.**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**259**	Frequency of service
1991	**Complete x-ray procedure denied. Technical component of this procedure has been reimbursed within a year, same or different provider. Rebill for professional component only.**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**259**	Frequency of service
1991	**Complete x-ray procedure denied. Technical component of this procedure has been reimbursed within a year, same or different provider. Rebill for professional component only.**	**A1**	Claim-Service denied	**N13**	Payment based on professional technical component modifier(s).	**318**	X-rays
1991	**Complete x-ray procedure denied. Technical component of this procedure has been reimbursed within a year, same or different provider. Rebill for professional component only.**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**318**	X-rays

1991	**Complete x-ray procedure denied. Technical component of this procedure has been reimbursed within a year, same or different provider. Rebill for professional component only.**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**318**	X-rays
1992	**Complete x-ray procedure denied. Professional component of this procedure already reimbursed within a year, same or different provider. Rebill for technical component only.**	**A1**	Claim-Service denied	**N13**	Payment based on professional technical component modifier(s).	**259**	Frequency of service
1992	**Complete x-ray procedure denied. Professional component of this procedure already reimbursed within a year, same or different provider. Rebill for technical component only.**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**259**	Frequency of service
1992	**Complete x-ray procedure denied. Professional component of this procedure already reimbursed within a year, same or different provider. Rebill for technical component only.**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**259**	Frequency of service
					Payment based on professional		

1992	**Complete x-ray procedure denied. Professional component of this procedure already reimbursed within a year, same or different provider. Rebill for technical component only.**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**318**	X-rays
1992	**Complete x-ray procedure denied. Professional component of this procedure already reimbursed within a year, same or different provider. Rebill for technical component only.**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**318**	X-rays
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.
1998	**Duplicate claim, same DOS, Admit hour and NDC number.**	**18**	Exact duplicate claim-service	**N20**	Service not payable with other service rendered on the same date.	**54**	Duplicate of a previously processed claim-line.
1998	**Duplicate claim, same DOS, Admit hour and NDC number.**	**18**	Exact duplicate claim-service	**N20**	Service not payable with other service rendered on the same date.	**218**	NDC number

1999	**MEDICAL RECORDS AND STATEMENT FAIL TO INDICATE NEED FOR EMERGENCY HYSTERECTOMY. SUBMIT ADJUSTMENT CLAIM AND RECORDS WITH "PRIOR TO MY SURGERY" HYSTERECTOMY STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-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.
1999	**MEDICAL RECORDS AND STATEMENT FAIL TO INDICATE NEED FOR EMERGENCY HYSTERECTOMY. SUBMIT ADJUSTMENT CLAIM AND RECORDS WITH "PRIOR TO MY SURGERY" HYSTERECTOMY STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N163**	Medical Record does not support code billed per the code definition	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1999	**MEDICAL RECORDS AND STATEMENT FAIL TO INDICATE NEED FOR EMERGENCY HYSTERECTOMY. SUBMIT ADJUSTMENT CLAIM AND RECORDS WITH "PRIOR TO MY SURGERY" HYSTERECTOMY STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-incomplete-invalid documentation-orders-notes-summary-report-chart.	**297**	Medical notes-report.

1999	**MEDICAL RECORDS AND STATEMENT FAIL TO INDICATE NEED FOR EMERGENCY HYSTERECTOMY. SUBMIT ADJUSTMENT CLAIM AND RECORDS WITH "PRIOR TO MY SURGERY" HYSTERECTOMY STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N163**	Medical Record does not support code billed per the code definition	**297**	Medical notes-report.
1999	**MEDICAL RECORDS AND STATEMENT FAIL TO INDICATE NEED FOR EMERGENCY HYSTERECTOMY. SUBMIT ADJUSTMENT CLAIM AND RECORDS WITH "PRIOR TO MY SURGERY" HYSTERECTOMY STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-incomplete-invalid documentation-orders-notes-summary-report-chart.	**471**	Were services related to an emergency?
1999	**MEDICAL RECORDS AND STATEMENT FAIL TO INDICATE NEED FOR EMERGENCY HYSTERECTOMY. SUBMIT ADJUSTMENT CLAIM AND RECORDS WITH "PRIOR TO MY SURGERY" HYSTERECTOMY STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N163**	Medical Record does not support code billed per the code definition	**471**	Were services related to an emergency?
2000	**Procedure limited to one per lifetime**	**35**	Lifetime benefit maximum has been reached.	**N117**	This service is paid only once in a patients lifetime.	**259**	Frequency of service
2000	**Procedure limited to one per lifetime**	**35**	Lifetime benefit maximum has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service

2001	**Community inclusion service recouped-denied to pay supported living.**	**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.
2004	**Related psychiatric procedures 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
2006	**Related psychological procedures 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
2010	**Adult health assessment limited to one 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.
2010	**Adult health assessment limited to one 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

2012	**Related immunization and administration procedures 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.
2014	**Related IUD procedure 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
2015	**IV infusion for therapy or diagnosis not allowed same date of service as prolonged service.**	**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.

2016	**Prolonged service not allowed same date of service as IV infusion for therapy or diagnosis.**	**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.
2017	**IV infusion for therapy or diagnosis, up to one hour allowed only once 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.
2017	**IV infusion for therapy or diagnosis, up to one hour allowed only once 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
2019	**Fetal monitoring recouped; reimbursement has been made to hospital.**	**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.
2020	**Incision to appendix allowed only once per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
2020	**Incision to appendix allowed only once per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount

2022	**NICU and prolonged services not allowed on the same date as service. Prolonged service has already paid for this 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
2023	**Observation and prolonged service not allowed on the same date of service. Prolonged service already paid for this 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
2024	**UB82 claims are no longer accepted. Please re-submit using the ub92 format.**	**16**	Claim-service lacks information which is needed for adjudication	**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.
2024	**UB82 claims are no longer accepted. Please re-submit using the ub92 format.**	**16**	Claim-service lacks information which is needed for adjudication	**N34**	Incorrect claim form-format for this service.	**228**	Type of bill for UB claim
2025	**NICU service not payable to this provider specialty.**	**170**	Payment is denied when performed-billed by this type of provider	**N95**	This provider type - provider specialty may not bill this service.	**91**	Entity not eligible-not approved for dates of service.
2026	**THIS SERVICE IS NOT PAYABLE TO YOUR PROVIDER TYPE AND SPECIALTY ACCORDING TOPOLICY GUIDELINES**	**170**	Payment is denied when performed-billed by this type of provider	**N95**	This provider type - provider specialty may not bill this service.	**88**	Entity not eligible for submitted dates of service.

2027	**State assigned diagnosis code for Health department use only. Correct and resubmit as new day claim.**	**12**	The diagnosis is inconsistent with the provider type	**M76**	Missing-incomplete-invalid diagnosis or condition.	**255**	Diagnosis code.
2028	**Orchiectomy allowed once per DOS.**	**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.
2028	**Orchiectomy allowed once per DOS.**	**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
2029	**Service recouped. Orchiectomy previously paid for the same date of service.**	**18**	Exact duplicate claim-service	**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
2030	**CLAIM DENIED. AUTHORIZATION FOR SERVICE BY OUT OF STATE PROVIDER WAS NOT OBTAINED. APPEALS MAY BE SENT TO THE DIVISION OF MEDICAL ASSISTANCE**	**A1**	Claim-Service denied	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**252**	Authorization-certification number.
2031	**Related norplant procedures 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.
2032	**Daily management of epidural denied, not allowed same day as epidural procedure, same or different provider**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.

2033	**AUTHORIZATION FOR SERVICE RENDERED BY OUT OF STATE PROVIDER WAS NOT OBTAINED/PREVIOUSLY DENIED. YOUR ADJUSTMENT HAS BEEN REFERRED TO THE DIVISION OF MEDICAL ASSISTANCE**	**165**	Referral absent or exceeded.	**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.	**252**	Authorization-certification number.
2034	**Daily management of epidural recouped, not allowed same day as epidural procedure, same or different provider**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
2035	**Rental and purchase of Cap-MR-DD augmentative communication devices not allowed on same date of service.**	**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.
2036	**CLAIM DENIED. AUTHORIZATION FOR SERVICES PROVIDED BY OUT OF STATE PROVIDER WERE PREVIOUSLY DENIED. APPEALS MAY BE SENT TO THE DIVISION OF MEDICAL ASSISTANCE**	**A1**	Claim-Service denied	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**252**	Authorization-certification number.

2038	**Rental and repairs of augmentative communication devices not allowed on the 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.
2039	**Medicaid does not make separate payment for procedures that are components of a more comprehensive service already pd for the 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**258**	Days-units for procedure-revenue code.
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.
2041	**Lock-in management fee must be numeric**	**16**	Claim-service lacks information which is needed for adjudication	**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.
2041	**Lock-in management fee must be numeric**	**16**	Claim-service lacks information which is needed for adjudication	**M79**	Missing-incomplete-invalid charge	**585**	Denied Charge or Non-covered Charge.
2042	**Lock-in management fee claim cannot exceed $30.00**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**178**	Submitted charges
2042	**Lock-in management fee claim cannot exceed $30.00**	**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
2043	**Recipient is not locked to provider on this date of service**	**177**	Patient has not met the required eligibility requirements.	**N362**	Claim must meet primary payers processing requirements before we can consider payment.	**93**	Entity is not selected primary care provider.
2043	**Recipient is not locked to provider on this date of service**	**177**	Patient has not met the required eligibility requirements.	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**93**	Entity is not selected primary care provider.
2043	**Recipient is not locked to provider on this date of service**	**177**	Patient has not met the required eligibility requirements.	**N362**	Claim must meet primary payers processing requirements before we can consider payment.	**187**	Date(s) of service

2043	**Recipient is not locked to provider on this date of service**	**177**	Patient has not met the required eligibility requirements.	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**187**	Date(s) of service
2044	**Management fee already paid for this quarter**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**65**	Claim-line has been paid.
2044	**Management fee already paid for this quarter**	**A1**	Claim-Service denied	**N182**	This claim-service must be billed according to the schedule for this plan.	**65**	Claim-line has been paid.
2044	**Management fee already paid for this quarter**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**65**	Claim-line has been paid.
2044	**Management fee already paid for this quarter**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**107**	Processed according to contract-plan provisions.
2044	**Management fee already paid for this quarter**	**A1**	Claim-Service denied	**N182**	This claim-service must be billed according to the schedule for this plan.	**107**	Processed according to contract-plan provisions.
2044	**Management fee already paid for this quarter**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**107**	Processed according to contract-plan provisions.
2044	**Management fee already paid for this quarter**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**643**	Service Line Paid Amount.
2044	**Management fee already paid for this quarter**	**A1**	Claim-Service denied	**N182**	This claim-service must be billed according to the schedule for this plan.	**643**	Service Line Paid Amount.
2044	**Management fee already paid for this quarter**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**643**	Service Line Paid Amount.
2045	**Management fee paid to another provider for this quarter**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**65**	Claim-line has been paid.

2045	**Management fee paid to another provider for this quarter**	**A1**	Claim-Service denied	**N182**	This claim-service must be billed according to the schedule for this plan.	**65**	Claim-line has been paid.
2045	**Management fee paid to another provider for this quarter**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**65**	Claim-line has been paid.
2045	**Management fee paid to another provider for this quarter**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**107**	Processed according to contract-plan provisions.
2045	**Management fee paid to another provider for this quarter**	**A1**	Claim-Service denied	**N182**	This claim-service must be billed according to the schedule for this plan.	**107**	Processed according to contract-plan provisions.
2045	**Management fee paid to another provider for this quarter**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**107**	Processed according to contract-plan provisions.
2045	**Management fee paid to another provider for this quarter**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**643**	Service Line Paid Amount.
2045	**Management fee paid to another provider for this quarter**	**A1**	Claim-Service denied	**N182**	This claim-service must be billed according to the schedule for this plan.	**643**	Service Line Paid Amount.
2045	**Management fee paid to another provider for this quarter**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**643**	Service Line Paid Amount.
2046	**Adjustment request denied. Adjustment-replacement claims for specialized therapy services will be adjusted systematically**	**A1**	Claim-Service denied	**N185**	**Alert-** Do not resubmit this claim-service.	**45**	Awaiting benefit determination.
2046	**Adjustment request denied. Adjustment-replacement claims for specialized therapy services will be adjusted systematically**	**A1**	Claim-Service denied	**N377**	Payment based on a processed replacement claim.	**45**	Awaiting benefit determination.
2049	**Management fee request invalid for this function**	**A1**	Claim-Service denied	**M79**	Missing-incomplete-invalid charge.	**107**	Processed according to contract-plan provisions.
2049	**Management fee request invalid for this function**	**A1**	Claim-Service denied	**N185**	**Alert-** Do not resubmit this claim-service.	**107**	Processed according to contract-plan provisions.

2049	**Management fee request invalid for this function**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**107**	Processed according to contract-plan provisions.
2049	**Management fee request invalid for this function**	**A1**	Claim-Service denied	**M79**	Missing-incomplete-invalid charge.	**585**	Denied Charge or Non-covered Charge.
2049	**Management fee request invalid for this function**	**A1**	Claim-Service denied	**N185**	**Alert-** Do not resubmit this claim-service.	**585**	Denied Charge or Non-covered Charge.
2049	**Management fee request invalid for this function**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**585**	Denied Charge or Non-covered Charge.
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.
2051	**Related therapy treatment procedures 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.
2053	**Related speech and hearing services 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.

2054	**Related physical therapy service 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.
2056	**Related RHO D immune globulin limited to one 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.
2056	**Related RHO D immune globulin limited to one 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
2057	**Coordination of benefit reject count and amount paid count fields are submitted for the same coordination of benefits payment. Remove entry from one of the fields and resubmit**	**A1**	Claim-Service denied	**N245**	Incomplete-invalid plan information for other insurance	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2058	**Related diagnostic ultrasounds 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.

2060	**Related delivery procedures 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.
2062	**Related fetal non stress test 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.
2064	**DHS maternal Health Clinic Care and ante partum care 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.
2066	**Immunization administration and therapeutic injections not allowed same day as E-M.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered

2068	**Related immunization procedures 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.
2071	**Related contraceptive procedures 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.
2072	**Service denied. Exceeds maximum 8 units allowed per 365 days.**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code.
2072	**Service denied. Exceeds maximum 8 units allowed per 365 days.**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service
2074	**Only one annual exam allowed per 365 days for recipients 19 years of age and older.**	**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
2075	**Only one E-M code 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
2075	**Only one E-M code 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

2078	**Related developmental skills not allowed to bill 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.
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.
2080	**Related testing procedures 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.
2082	**Related diagnostic evaluation procedures 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.
2083	**PAMC or RX clarification override not allowed for PA emergency fills**	**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.

2084	**Related speech hearing and language procedures not allowed the 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.
2086	**DEC Neuromotor diagnosis and assessment not allowed same day as physical medicine and rehabilitation.**	**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.
2087	**Physical medicine and rehabilitation not allowed same day as DEC neuromotor diagnosis and assessment.**	**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.

2089	**Related therapeutic service procedures 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.
2091	**Related assessment- test 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.
2092	**E-M procedure codes not allowed same day as clinic visit.**	**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.

2095	**Supply of low vision aids must be billed with visual aid 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.	**MA66**	Missing-incomplete-invalid principal procedure code	**454**	Procedure code for services rendered
2096	**HCPCS code allowed only once per day, by same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
2097	**Only three HCPCS units of Provenge allowed per lifetime of recipient, admistered by same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
2097	**Only three HCPCS units of Provenge allowed per lifetime of recipient, admistered by same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**574**	HCPCS Payable Amount Home Health
2097	**Only three HCPCS units of Provenge allowed per lifetime of recipient, admistered by same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service
2097	**Only three HCPCS units of Provenge allowed per lifetime of recipient, admistered by same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**574**	HCPCS Payable Amount Home Health
2098	**Related vaccines, tetanus and diptheria toxoids, are not allowed on the same date of service**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
2098	**Related vaccines, tetanus and diptheria toxoids, are not allowed on the same date of service**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.

2099	**Effective 10/01/2011 the medical eye exam code billed is not allowed when the only diagnosis code(s) on the claim indicate the service was performed for refraction**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.
2100	**Invalid TOT billed, 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.
2100	**Invalid TOT billed, correct and resubmit claim.**	**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.
2100	**Invalid TOT billed, 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.	**250**	Type of service.
2100	**Invalid TOT billed, correct and resubmit claim.**	**125**	Submission-billing error(s)	**N56**	Procedure code billed is not correct-valid for the services billed or the date of service billed	**250**	Type of service.
2107	**Crossover claims not allowed for provider type and specialty.**	**170**	Payment is denied when performed-billed by this type of provider	**N95**	This provider type - provider specialty may not bill this service.	**258**	Days-units for procedure-revenue code.
2109	**For DOS 12-01-2007 thru 12-31-2008, procedure requires secondary modifier of U3 or U4. Append appropriate secondary modifier and resubmit.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

2109	**For DOS 12-01-2007 thru 12-31-2008, procedure requires secondary modifier of U3 or U4. Append appropriate secondary modifier and resubmit.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**N291**	Missing-incomplete-invalid rending provider secondary identifier.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2109	**For DOS 12-01-2007 thru 12-31-2008, procedure requires secondary modifier of U3 or U4. Append appropriate secondary modifier and resubmit.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
2109	**For DOS 12-01-2007 thru 12-31-2008, procedure requires secondary modifier of U3 or U4. Append appropriate secondary modifier and resubmit.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**N291**	Missing-incomplete-invalid rending provider secondary identifier.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
2110	**For DOS 12-01-2007 thru 12-31-2008, modifier U3 or U4 must be billed in the secondary position. Please review claim, correct and resubmit.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2110	**For DOS 12-01-2007 thru 12-31-2008, modifier U3 or U4 must be billed in the secondary position. Please review claim, correct and resubmit.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**N291**	Missing-incomplete-invalid rending provider secondary identifier.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2110	**For DOS 12-01-2007 thru 12-31-2008, modifier U3 or U4 must be billed in the secondary position. Please review claim, correct and resubmit.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**453**	Procedure Code Modifier(s) for Service(s) Rendered

2110	**For DOS 12-01-2007 thru 12-31-2008, modifier U3 or U4 must be billed in the secondary position. Please review claim, correct and resubmit.**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**N291**	Missing-incomplete-invalid rending provider secondary identifier.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
2112	**Limitation for this CAPMR service for this waiver year, has been exceeded by the same or different provider**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	**483**	Maximum coverage amount met or exceeded for benefit period.
2113	**Units cutback. Maximum number of units per year exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
2113	**Units cutback. Maximum number of units per year exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	**Frequency of service.**
2113	**Units cutback. Maximum number of units per year exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**483**	Maximum coverage amount met or exceeded for benefit period
2113	**Units cutback. Maximum number of units per year exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period
2114	**Units cutback. Maximum number of units per year exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
2114	**Units cutback. Maximum number of units per year exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
2114	**Units cutback. Maximum number of units per year exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	**Frequency of service.**
2114	**Units cutback. Maximum number of units per year exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	**Frequency of service.**
2115	**Molecular diagnostics and HIV 1&2 quantification procedures limited to 1 unit/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.	**258**	Days-units for procedure-revenue code.

2115	**Molecular diagnostics and HIV 1&2 quantification procedures limited to 1 unit/year**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
2115	**Molecular diagnostics and HIV 1&2 quantification procedures limited to 1 unit/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.
2115	**Molecular diagnostics and HIV 1&2 quantification procedures limited to 1 unit/year**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
2116	**Infectious agent phenotype analysis procedure limited to 9 units 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.
2116	**Infectious agent phenotype analysis procedure limited to 9 units per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
2117	**Nuclear/Molecular diagnostic procedures limited to 2/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.	**259**	Frequency of service.
2117	**Nuclear/Molecular diagnostic procedures limited to 2/year.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
2117	**Nuclear/Molecular diagnostic procedures limited to 2/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.
2117	**Nuclear/Molecular diagnostic procedures limited to 2/year.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.

2118	**Sodium fluoride diagnostic procedure mus bill with a PET Imaging 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.	**MA66**	Missing-incomplete-invalid principal procedure code	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2118	**Sodium fluoride diagnostic procedure mus bill with a PET Imaging 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.	**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.
2118	**Sodium fluoride diagnostic procedure mus bill with a PET Imaging 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.	**MA66**	Missing-incomplete-invalid principal procedure code	**465**	Principal Procedure Code for Service(s) Rendered

2118	**Sodium fluoride diagnostic procedure mus bill with a PET Imaging 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.	**M51**	Missing-incomplete-invalid procedure code(s).	**465**	Principal Procedure Code for Service(s) Rendered
2119	**Regadenoson must bill with cardiovasuclar imaging or stress test procedures.**	**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.	**MA66**	Missing-incomplete-invalid principal procedure code	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2119	**Regadenoson must bill with cardiovasuclar imaging or stress test procedures.**	**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).	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

2119	**Regadenoson must bill with cardiovasuclar imaging or stress test procedures.**	**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.	**MA66**	Missing-incomplete-invalid principal procedure code	**465**	Principal Procedure Code for Service(s) Rendered
2119	**Regadenoson must bill with cardiovasuclar imaging or stress test procedures.**	**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
2120	**Infectious agent phenotype analysis procedure limited to one unit per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
2120	**Infectious agent phenotype analysis procedure limited to one unit per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
2120	**Infectious agent phenotype analysis procedure limited to one unit per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
2120	**Infectious agent phenotype analysis procedure limited to one unit per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount

2121	**After hours visit not allowed with ER visits for 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.
2122	**After hour visit recouped. ER visit not allowed same date of service as after hour visit.**	**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.
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.
2124	**Service recouped. Similar incision to appendix previously paid same date of 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.	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
2124	**Service recouped. Similar incision to appendix previously paid same date of 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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered
2130	**Drainage of lymphocele to peritoneal cavity allowed once per DOS.**	**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.
2130	**Drainage of lymphocele to peritoneal cavity allowed once per DOS.**	**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
2131	**Service recouped. Drainage of lymphocele to peritoneal cavity previously pd same DOS.**	**18**	Exact duplicate claim-service	**N20**	Service not payable with other service rendered on the same date.	**54**	Duplicate of a previously processed claim-line.
2132	**Renal incision allowed only once per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

2132	**Renal incision allowed only once per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
2133	**Service recouped. Renal incision previously paid under similar procedure, same date of 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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered
2134	**Only one enterolysis procedure allowed per DOS.**	**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.
2134	**Only one enterolysis procedure allowed per DOS.**	**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
2135	**Service recouped. Only one enterolysis procedure per DOS.**	**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.
2135	**Service recouped. Only one enterolysis procedure per DOS.**	**169**	Alternate benefit has been provided	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**258**	Days-units for procedure-revenue code.
2135	**Service recouped. Only one enterolysis procedure per DOS.**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
2135	**Service recouped. Only one enterolysis procedure per DOS.**	**169**	Alternate benefit has been provided	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**259**	Frequency of service.
2140	**One transperineal or abdominal closure of rectovaginal fistula allowed per DOS.**	**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.
2140	**One transperineal or abdominal closure of rectovaginal fistula allowed per DOS.**	**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

2141	**Service recouped. Transperineal approach previously pd under abd approach to closure of rectovaginal fistula.**	**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.
2142	**Radical trachelectomy not allowed on the same DOS as total abd hysterectomy.**	**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.
2143	**Total abd. Hysterectomy not allowed same DOS as radical trachelectomy.**	**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.
2144	**Catheterization and contrast material intro included in hysterosonography.**	**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.

2145	**Service recouped, catherization and contrast material introduction previously pd under hysterosonography.**	**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.
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.
2147	**DOS not between 10-1-02 and 9-5-04, submit a Medicare Xover claim. DOS 10-1-02 through 9-5-04, submit a Medicaid claim. Split detail lines by DOS - resubmit appropriate claim(s)**	**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.
2147	**DOS not between 10-1-02 and 9-5-04, submit a Medicare Xover claim. DOS 10-1-02 through 9-5-04, submit a Medicaid claim. Split detail lines by DOS - resubmit appropriate claim(s)**	**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.
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.
2150	**Single study not allowed same DOS as multiple studies.**	**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.
2151	**Service recouped. Single study kidney imaging previously pd as multiple studies procedure.**	**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.

2152	**Kidney imaging w-out pharmacological intervention not allowed same DOS as imaging w intervention.**	**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.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**258**	Days-units for procedure-revenue code.
2153	**Service recouped. Kidney imaging without pharmacological intervention previously paid under imaging with intervention.**	**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.	**259**	Frequency of service.
2153	**Service recouped. Kidney imaging without pharmacological intervention previously paid under imaging with intervention.**	**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
2154	**CD4 count not allowed same DOS as similar Tcell 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.

2155	**Service recouped. Cd4 count previously paid same date of service as similar tcell procedure.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered
2156	**Procedures including similar E-M service allowed once- DOS.**	**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.
2157	**For DOS 10-1-02 through 9-5-04 NC Medicaid will not process Medicare crossover claims. Dates of Service indicate this claim must be resubmitted as a professional Medicare TPL claim.**	**125**	Submission-billing error(s)	**N34**	Incorrect claim form-format for this service.	**481**	Claim-submission format is invalid.
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**	Entitys address.
2160	**RH or FQHC visit not allowed same day as general visit.**	**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.

2161	**General clinic visit not allowed same day as RHC or FQHC.**	**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.
2162	**General clinic visit not allowed same day as Medicare detail for crossover processing.**	**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.	**54**	Duplicate of a previously processed claim-line.
2163	**Medicare detail for crossover processing not allowed same day as general clinic visit.**	**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.

2164	**Office visit not allowed same day as general clinic.**	**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.
2165	**General clinic visit not allowed as same day Office visit.**	**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.
2166	**Multiple Office visits not allowed for crossover processing.**	**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.

2167	**Multiple clinic visits not allowed for crossover processing.**	**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.
2168	**Office visits not allowed to bill the same day as medical care for crossover processing.**	**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.
2169	**Medical care for crossover processing not allowed to bill same date as Office visit.**	**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.

2170	**Office visit not allowed to bill with clinic visit and FQHC core services.**	**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.
2171	**Clinic visit and FQHC core services not allowed to bill with office visit.**	**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.
2172	**Medical care for crossover processing not allowed to bill the same date as Office visit.**	**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.

2173	**Office visit not allowed to bill the same date as medical care for crossover processing.**	**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.
2174	**General clinic visit not allowed same day as Office visit.**	**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.
2175	**Office visit not allowed same day as Gen clinic.**	**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.
2176	**Medicare payment indicated for this claim. Medicare does not cover procedures with EP Modifier. Rebill Health Check svcs. separately from procedures related to Medicare payment.**	**125**	Submission-billing error(s)	**N63**	Rebill services on separate claims lines.	**454**	Procedure code for services rendered.

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.
2178	**NCPDP Origin Code Is Invalid**	**125**	Submission-billing error(s)	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2179	**Diagnosis billed is not valid for the service rendered for the recipient's age or sex.**	**125**	Submission-billing error(s)	**MA39**	Missing-incomplete-invalid gender.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2179	**Diagnosis billed is not valid for the service rendered for the recipient's age or sex.**	**125**	Submission-billing error(s)	**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.
2179	**Diagnosis billed is not valid for the service rendered for the recipient's age or sex.**	**125**	Submission-billing error(s)	**MA39**	Missing-incomplete-invalid gender.	**86**	Diagnosis and patient gender mismatch.
2179	**Diagnosis billed is not valid for the service rendered for the recipient's age or sex.**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**86**	Diagnosis and patient gender mismatch.

2180	**Billed procedure included in similar heart catheterization procedure.**	**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.
2181	**Service recouped. Heart catheterization previously paid as similar procedure.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
2182	**Maximal voluntary ventilation included in similar pulmonary procedure.**	**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.
2183	**Service recouped. Maximal voluntary ventilation previously paid as related pulmonary procedure.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.

2184	**Service recouped. Billed procedure previously paid under sleep study on same date of 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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
2185	**Procedure 95807 included this 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.
2186	**CPAP ventilation included in sleep staging procedure.**	**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.
2187	**Service recouped. Cpap ventilation previously paid as sleep staging procedure on the same date of 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.	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.

2187	**Service recouped. Cpap ventilation previously paid as sleep staging procedure on the same date of 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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
2188	**Component tests included in polysomnography**	**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.	**N19**	Procedure code incidental to primary procedure.	**107**	Processed according to contract-plan provisions.
2188	**Component tests included in polysomnography**	**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.	**N20**	Service not payable with other service rendered on the same date.	**107**	Processed according to contract-plan provisions.
2188	**Component tests included in polysomnography**	**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	**107**	Processed according to contract-plan provisions.

2188	**Component tests included in polysomnography**	**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.	**N19**	Procedure code incidental to primary procedure.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
2188	**Component tests included in polysomnography**	**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.	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
2188	**Component tests included in polysomnography**	**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	**453**	Procedure Code Modifier(s) for Service(s) Rendered
2189	**Recoup. Polysomnography includes component tests**	**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.	**N19**	Procedure code incidental to primary procedure.	**107**	Processed according to contract-plan provisions.

2189	**Recoup. Polysomnography includes component tests**	**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.	**N20**	Service not payable with other service rendered on the same date.	**107**	Processed according to contract-plan provisions.
2189	**Recoup. Polysomnography includes component tests**	**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	**107**	Processed according to contract-plan provisions.
2189	**Recoup. Polysomnography includes component tests**	**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.	**N19**	Procedure code incidental to primary procedure.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
2189	**Recoup. Polysomnography includes component tests**	**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.	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered

2189	**Recoup. Polysomnography includes component tests**	**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	**453**	Procedure Code Modifier(s) for Service(s) Rendered
2190	**Single extremity Electromyography not same date of service as two or more extremities.**	**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.
2191	**Service recouped. Single extremity procedure previously paid as multiple extremity on same date of 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.	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
2191	**Service recouped. Single extremity procedure previously paid as multiple extremity on same date of 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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered
2192	**One discharge management service allowed per DOS.**	**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.

2192	**One discharge management service allowed per DOS.**	**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
2193	**Service recouped. Physician standby service previously paid as attendance at delivery on the same date of 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.	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
2193	**Service recouped. Physician standby service previously paid as attendance at delivery on the same date of 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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered
2194	**Physician standby not allowed same DOS as attendance at delivery.**	**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.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**258**	Days-units for procedure-revenue code.
2196	**Intestinal resection w anastomosis allowed once per DOS.**	**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.
2196	**Intestinal resection w anastomosis allowed once per DOS.**	**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

2197	**Service recouped. Intestinal resection with anastomosis previously paid as similar procedure on the same date of service.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
2198	**Esophagogastric fundoplasty allowed once per DOS.**	**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.
2198	**Esophagogastric fundoplasty allowed once per DOS.**	**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
2199	**Service recouped. esophagogastric fundoplasty previously pd as similar procedure on the same DOS.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered
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.
2203	**Reserved UB information/code. Check admit type, condition value, occurrence span or occurrence code(s), correct and resubmit if applicable.**	**125**	Submission-billing error(s)	**M44**	Missing-incomplete-invalid condition code.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

2203	**Reserved UB information/code. Check admit type, condition value, occurrence span or occurrence code(s), correct and resubmit if applicable.**	**125**	Submission-billing error(s)	**M45**	Missing-incomplete-invalid occurrence code(s).	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2203	**Reserved UB information/code. Check admit type, condition value, occurrence span or occurrence code(s), correct and resubmit if applicable.**	**125**	Submission-billing error(s)	**M46**	Missing-incomplete-invalid occurrence span code(s).	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2206	**V700 must be primary diagnosis for E-M screening visit for recipient age 22-65.**	**9**	The diagnosis is inconsistent with the patients age.	**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.
2206	**V700 must be primary diagnosis for E-M screening visit for recipient age 22-65.**	**9**	The diagnosis is inconsistent with the patients age.	**M76**	Missing-incomplete-invalid diagnosis or condition.	**254**	Primary diagnosis code.
2207	**Verify diagnosis and procedure code. Health Dept not allowed to bill unless this is a family planning visit.**	**11**	The diagnosis is inconsistent with the procedure.	**MA66**	Missing-incomplete-invalid principal procedure code or date.	**258**	Days-units for procedure-revenue code.
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 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.
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).	**453**	Procedure Code Modifier(s) for Service(s) Rendered
					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).	**453**	Procedure Code Modifier(s) for Service(s) Rendered
2218	**MONEY FOLLOWS THE PERSON (MFP) - TRANSITION SERVICES CUTBACK TO THE MAXIMUM ALLOWABLE DOLLAR LIMITATION PER 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.
2219	**MONEY FOLLOWS THE PERSON (MFP) - TRANSITION COORDINATION SERVICES PER YEAR DOLLAR LIMITATION HAS BEEN EXCEEDED**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	**M139**	Denied services exceed the coverage limit for the demonstration.	**483**	Maximum coverage amount met or exceeded for benefit period.
2220	**Provider must respond to the early refill Alert in order for the claim to process**	**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.
2221	**An invalid diagnosis-ICD-9 code was submitted on the claim**	**125**	Submission-billing error(s)	**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.

2221	**An invalid diagnosis-ICD-9 code was submitted on the claim**	**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.
2221	**An invalid diagnosis-ICD-9 code was submitted on the claim**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered
2221	**An invalid diagnosis-ICD-9 code was submitted on the claim**	**125**	Submission-billing error(s)	**MA66**	Missing-incomplete-invalid principal procedure code or date.	**488**	Diagnosis code(s) for the services 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.
2223	**Diagnosis billed is not valid for the service rendered for the recipient's age.**	**125**	Submission-billing error(s)	**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.
2223	**Diagnosis billed is not valid for the service rendered for the recipient's age.**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.
2224	**Claim Recouped. SCU-A not allowed same day as hospice services**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
2224	**Claim Recouped. SCU-A not allowed same day as hospice services**	**169**	Alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
2229	**There is not an approved FL-2 file for the billed NF level of care for the date of service.**	**197**	Precertification-authorization-notification absent.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**48**	Referral-authorization.

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
2235	**This ACH provider not authorized to receive enhanced ACH- PC payment for this resident on DOS billed. Contact ACH Case Manager**	**184**	The prescribing-ordering provider is not eligible to prescribe-order the service billed	**N95**	This provider type - provider specialty may not bill this service.	**91**	Entity not eligible-not approved for dates of service.
2236	**This resident not authorized on the DOS billed for enhanced ACH- PC coverage. Contact ACH Case Manager**	**177**	Patient has not met the required eligibility requirements.		**No Mapping Required**	**84**	Service not authorized
2237	**The level of enhanced ACH- PC coverage billed is not authorized for this resident on the DOS billed. Contact ACH Case Manager**	**177**	Patient has not met the required eligibility requirements.		**No Mapping Required**	**84**	Service not authorized
2238	**This resident not authorized for enhanced ACH- PC coverage. Contact ACH case manager.**	**177**	Patient has not met the required eligibility requirements.		**No Mapping Required**	**84**	Service not authorized
2239	**Recoup state payout - DMA requested.**	**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.
2240	**Case management services should be billed through CAP-MR-DD area programs.**	**15**	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider	**N95**	This provider type - provider specialty may not bill this service.	**91**	Entity not eligible-not approved for dates of service.

2241	**Principal adjustment setup for zero dollars reflecting penalty-interest assessment on large dollar provider refunds.**	**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.
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 service. Note- Refer to the 835 Healthcare Policy Identification		**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.
2264	**Testopel is limited to 6 units per 3 months.**	**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.
2264	**Testopel is limited to 6 units per 3 months.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
2264	**Testopel is limited to 6 units per 3 months.**	**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.
					between this service-procedure-		

2265	**Units Cutback. Maximum number of units per 3 monts exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
2265	**Units Cutback. Maximum number of units per 3 monts exceeded.**	**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.
2270	**SVC MUST BE REFERRED BY CA PCP, LME OR MEDICAID ENROLLED PSYCHIATRIST. REFERRAL # ON CLAIM IS MISSING OR UNRESOLVED. CONTACT HP PROVIDER SVCS IF REFERRAL # IS CORRECT**	**165**	Payment denied-reduced for absence of, or exceeded referral.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**48**	Referral-authorization.
2270	**SVC MUST BE REFERRED BY CA PCP, LME OR MEDICAID ENROLLED PSYCHIATRIST. REFERRAL # ON CLAIM IS MISSING OR UNRESOLVED. CONTACT HP PROVIDER SVCS IF REFERRAL # IS CORRECT**	**165**	Payment denied-reduced for absence of, or exceeded referral.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**252**	Authorization-certification number.
2270	**SVC MUST BE REFERRED BY CA PCP, LME OR MEDICAID ENROLLED PSYCHIATRIST. REFERRAL # ON CLAIM IS MISSING OR UNRESOLVED. CONTACT HP PROVIDER SVCS IF REFERRAL # IS CORRECT**	**165**	Payment denied-reduced for absence of, or exceeded referral.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**94**	Entity not referred by selected primary care provider.
2275	**Drug is limited to 240 units per calendar month. Units for this timeframe have been exceeded**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**259**	Frequency of service

2279	**This recipient is not an SA eligible recipient; therefore this service is being denied.**	**177**	Patient has not met the required eligibility requirements.		**No Mapping Required**	**91**	Entity not eligible-not approved for dates of service.
2280	**Claim Denied. SCU-A Services not allowed same day as hospice.**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
2280	**Claim Denied. SCU-A Services not allowed same day as hospice.**	**169**	Alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
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.
2282	**The POA/HAC indicatior submitted in relation to the diagnosis billed is invalid or does not allow for the diagnosis to be grouped to a payable DRG. Correct and resubmit**	**125**	Submission-billing error(s)	**M76**	**Missing-incomplete-invalid diagnosis or condition.**	**488**	Diagnosis code(s) for the services rendered.
2324	**Candida, gardnerella and trichomonas are all included in the same fee.**	**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.
2330	**Service denied. CAPMR procedure code billed is not supported by the recipient's waiver enrollment**	**204**	This service-equipment-drug is not covered under the patients current benefit plan	**N216**	**We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package**	**453**	Procedure Code Modifier(s) for Service(s) Rendered

2337	**Must use preferred vendor-prodigy**	**A1**	Claim-Service denied	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2337	**Must use preferred vendor-prodigy**	**A1**	Claim-Service denied	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**25**	Entity not approved.
2340	**Service Denied. Product no longer provided by medicaid. Resubmit w/preferred vendor-prodigy. Refer to http://www.ncdiabetes.org/FAQ 6 for override instructions**	**A1**	Claim-Service denied	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2340	**Service Denied. Product no longer provided by medicaid. Resubmit w/preferred vendor-prodigy. Refer to http://www.ncdiabetes.org/FAQ 6 for override instructions**	**A1**	Claim-Service denied	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**25**	Entity not approved.
2351	**Claim Denied. Case management service with modifier indicating assessment units, exceeds annual 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.
2351	**Claim Denied. Case management service with modifier indicating assessment units, exceeds annual limit**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
2375	**Allow one oral evaluation every 60 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.

2375	**Allow one oral evaluation every 60 days.**	**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.
2375	**Allow one oral evaluation every 60 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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
2375	**Allow one oral evaluation every 60 days.**	**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	**453**	Procedure Code Modifier(s) for Service(s) Rendered
2379	**Personal Care Services for same recipient, same date of service not allowed by both Adult Care Home and PCS providers. Service is paid to another provider for this date**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**187**	Date(s) of service
2379	**Personal Care Services for same recipient, same date of service not allowed by both Adult Care Home and PCS providers. Service is paid to another**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**453**	Procedure Code Modifier(s) for Service(s) Rendered
					between this service-procedure-		

2380	**Claim has been recouped. Services for this recipient are covered by an HMO. Please call voice inquiry at 1-800-723-4337 to obtain information on responsible HMO**	**24**	Charges are covered under a capitation agreement-managed care plan		**No Mapping Required**	**96**	No agreement with entity.
2380	**Claim has been recouped. Services for this recipient are covered by an HMO. Please call voice inquiry at 1-800-723-4337 to obtain information on responsible HMO**	**24**	Charges are covered under a capitation agreement-managed care plan		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge.
2424	**Detail reviewed by pharmacy department. NDC units incorrect. NDC units must correspond to submitted HCPCS procedure units. Verify and resubmit correct NDC units.**	**211**	National Drug Codes (NDC) not eligible for rebate, are not covered.	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
2424	**Detail reviewed by pharmacy department. NDC units incorrect. NDC units must correspond to submitted HCPCS procedure units. Verify and resubmit correct NDC units.**	**211**	National Drug Codes (NDC) not eligible for rebate, are not covered.	**M53**	Missing-incomplete-invalid days or units of service.	**218**	NDC number.
2424	**Detail reviewed by pharmacy department. NDC units incorrect. NDC units must correspond to submitted HCPCS procedure units. Verify and resubmit correct NDC units.**	**211**	National Drug Codes (NDC) not eligible for rebate, are not covered.	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**218**	NDC number.

2424	**Detail reviewed by pharmacy department. NDC units incorrect. NDC units must correspond to submitted HCPCS procedure units. Verify and resubmit correct NDC units.**	**211**	National Drug Codes (NDC) not eligible for rebate, are not covered.	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**476**	Missing or invalid units of service
2424	**Detail reviewed by pharmacy department. NDC units incorrect. NDC units must correspond to submitted HCPCS procedure units. Verify and resubmit correct NDC units.**	**211**	National Drug Codes (NDC) not eligible for rebate, are not covered.	**M53**	Missing-incomplete-invalid days or units of service.	**476**	Missing or invalid units of service
2424	**Detail reviewed by pharmacy department. NDC units incorrect. NDC units must correspond to submitted HCPCS procedure units. Verify and resubmit correct NDC units.**	**211**	National Drug Codes (NDC) not eligible for rebate, are not covered.	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**476**	Missing or invalid units of service
2447	**DME allowed 8 per 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.	**259**	Frequency of service
2448	**DME allowed 18 per 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.	**259**	Frequency of service
2449	**DME allowed 6 per 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.	**259**	Frequency of service
2450	**DME allowed 1 per month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service

2451	**DME allowed 1 per 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.	**259**	Frequency of service
2452	**DME allowed 2 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
2453	**DME allowed 2 in three years**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
2454	**DME allowed 2 per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
2455	**DME allowed 3 per month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
2456	**DME allowed 4 per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
2457	**DME allowed 10 per month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
2458	**DME allowed 12 per month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
2459	**DME allowed 15 per month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
2460	**DME allowed 16 per month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service

2461	**DME allowed 50 per month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
2462	**DME allowed 60 per month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
2463	**DME allowed 100 per month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
2464	**DME allowed 150 per month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
2465	**DME allowed 200 per month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
2466	**DME allowed 300 per month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
2467	**DME allowed 720 per month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
2468	**DME allowed 2 per 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.	**259**	Frequency of service
2469	**DME allowed 4 per 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.	**259**	Frequency of service
2476	**Service denied. Exceeds the limitation of units allowed per state fiscal year, by the same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service

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.
2547	**Procedure not allowed for this age recipient.**	**6**	The procedure-revenue code is inconsistent with the patients age		**No Mapping Required**	**475**	Procedure code not valid for patient age.
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.
2602	**Invalid or missing first annual exam date.**	**A1**	Claim-Service denied	**N326**	Missing-incomplete-invalide last x-ray date.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2603	**Lab procedure date of service not within allowed time frame of annual exam date**	**A1**	Claim-Service denied	**N301**	Missing-incomplete-invalid procedure date(s).	**187**	Date(s) of service.
2603	**Lab procedure date of service not within allowed time frame of annual exam date**	**A1**	Claim-Service denied	**N301**	Missing-incomplete-invalid procedure date(s).	**653**	Test Performed Date
2604	**Diagnosis missing or not covered under the Family Planning Waiver**	**A1**	Claim-Service denied	**M76**	Missing-incomplete-invalid diagnosis or condition.	**255**	Diagnosis code.
2604	**Diagnosis missing or not covered under the Family Planning Waiver**	**A1**	Claim-Service denied	**N314**	Missing-incomplete-invalid diagnosis date.	**255**	Diagnosis code.
2604	**Diagnosis missing or not covered under the Family Planning Waiver**	**A1**	Claim-Service denied	**M76**	Missing-incomplete-invalid diagnosis or condition.	**345**	Treatment plan for service-diagnosis
2604	**Diagnosis missing or not covered under the Family Planning Waiver**	**A1**	Claim-Service denied	**N314**	Missing-incomplete-invalid diagnosis date.	**345**	Treatment plan for service-diagnosis

2604	**Diagnosis missing or not covered under the Family Planning Waiver**	**A1**	Claim-Service denied	**M76**	Missing-incomplete-invalid diagnosis or condition.	**557**	Diagnosis Date
2604	**Diagnosis missing or not covered under the Family Planning Waiver**	**A1**	Claim-Service denied	**N314**	Missing-incomplete-invalid diagnosis date.	**557**	Diagnosis Date
2606	**The diagnosis billed is not allowed for the combination of qualifying circumstance procedure and anesthesia service billed on this claim.**	**11**	The diagnosis is inconsistent with the procedure. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.
2607	**Service Recouped. Bypass graft not allowed same day as Bypass graft with Endovascular repair.**	**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.	**187**	Date(s) of service.
2607	**Service Recouped. Bypass graft not allowed same day as Bypass graft with Endovascular repair.**	**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.	**259**	Frequency of service.
2607	**Service Recouped. Bypass graft not allowed same day as Bypass graft with Endovascular repair.**	**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.
2610	**All unauthorized units have been exhausted. Prior Approval is now required.**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code.

2613	**Exceeds 30 units per calendar year maximum**	**119**	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.
2614	**Exceeds 480 units per calendar year maximum**	**119**	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.
2616	**Service denied. Procedure must be billed in whole unit increments**	**125**	Submission-billing errors. At least one Remark Code must be provided may be comprised of	**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
2616	**Service denied. Procedure must be billed in whole unit increments**	**125**	Submission-billing errors. At least one Remark Code must be provided may be comprised of	**M53**	Missing-incomplete-invalid days or units of service.	**454**	Procedure code for services rendered.
2621	**Service denied. Units have been exceeded per 30 days when billed in an inpatient setting.**	**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.
2621	**Service denied. Units have been exceeded per 30 days when billed in an inpatient setting.**	**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
2622	**Service denied. Maximum units allowed per day have been exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**258**	Days-units for procedure-revenue code.
2622	**Service denied. Maximum units allowed per day have been exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**259**	Frequency of service
2623	**Service denied. Intranasal/Oral vaccine administration procedure allowed one 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
2623	**Service denied. Intranasal/Oral vaccine administration procedure allowed one 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
2630	**Thank you for reporting additional wellness testing in conjunction with your wellness exam**	**246**	This non-payable code is for required reporting only	**N365**	This procedure code is not payable. It is for reporting-information purposes only	**454**	Procedure code for services rendered.
2638	**Units cutback. Maximum units allowed per day have been exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service

2638	**Units cutback. Maximum units allowed per day have been exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount
2639	**Units cutback. Exceeds the maximum units allowed per 30 days when billed in an inpatient setting.**	**119**	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
2640	**Implanon required to be billed with insertion-removal of implant**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
2640	**Implanon required to be billed with insertion-removal of implant**	**A1**	Claim-Service denied	**N161**	This drug-service-supply is covered only when the associated service is covered	**454**	Procedure code for services rendered.
2640	**Implanon required to be billed with insertion-removal of implant**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**490**	Other Procedure Code for Service(s) Rendered
2640	**Implanon required to be billed with insertion-removal of implant**	**A1**	Claim-Service denied	**N161**	This drug-service-supply is covered only when the associated service is covered	**490**	Other Procedure Code for Service(s) Rendered
2641	**Boniva limited to 3 units allowed per 90 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
2641	**Boniva limited to 3 units allowed per 90 days**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service
2642	**Orencial limited to 300 units per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
2642	**Orencial limited to 300 units per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service
2653	**Service denied. This administration of Provenge does not meet the approved Medicaid guidelines in relation to the recipient's previous payment history associated with the drug**	**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

2700	**Exceeds limitation(s) for waiver recipient**	**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
2706	**Bypass graft with endovascular repair not same day as other bypass graft.**	**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.	**187**	Date(s) of service. Frequency of service.
2706	**Bypass graft with endovascular repair not same day as other bypass graft.**	**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.	**259**	Frequency of service.
2706	**Bypass graft with endovascular repair not same day as other bypass graft.**	**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.

2719	**Surgical pathology must be billed within 10 days of sterilization for MAFD recipients**	**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.	**M67**	Missing-incomplete-invalid other procedure code(s).	**454**	Procedure code for services rendered.
2720	**Semen analysis must be billed within 90 days of sterilization for MAFD recipients**	**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.	**M67**	Missing-incomplete-invalid other procedure code(s).	**454**	Procedure code for services rendered.
2725	**Service Denied. Echocardiography procedure is not allowed on same date of service, by same or different provider when billed in conjunction with doppler echocardiography procedure.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
2725	**Service Denied. Echocardiography procedure is not allowed on same date of service, by same or different provider when billed in conjunction with doppler echocardiography procedure.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time.	**187**	Date(s) of service.

2725	**Service Denied. Echocardiography procedure is not allowed on same date of service, by same or different provider when billed in conjunction with doppler echocardiography procedure.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
2725	**Service Denied. Echocardiography procedure is not allowed on same date of service, by same or different provider when billed in conjunction with doppler echocardiography procedure.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
2725	**Service Denied. Echocardiography procedure is not allowed on same date of service, by same or different provider when billed in conjunction with doppler echocardiography procedure.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time.	**259**	Frequency of service.
2725	**Service Denied. Echocardiography procedure is not allowed on same date of service, by same or different provider when billed in conjunction with doppler echocardiography procedure.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.

2726	**Service Denied. Doppler Echocardiography procedure is not allowed on same date of service, by the same or different provider when in conjunction with echocardiography procedure.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
2726	**Service Denied. Doppler Echocardiography procedure is not allowed on same date of service, by the same or different provider when in conjunction with echocardiography procedure.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time	**187**	Date(s) of service.
2726	**Service Denied. Doppler Echocardiography procedure is not allowed on same date of service, by the same or different provider when in conjunction with echocardiography procedure.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
2726	**Service Denied. Doppler Echocardiography procedure is not allowed on same date of service, by the same or different provider when in conjunction with echocardiography procedure.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.

2726	**Service Denied. Doppler Echocardiography procedure is not allowed on same date of service, by the same or different provider when in conjunction with echocardiography procedure.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time	**259**	Frequency of service.
2726	**Service Denied. Doppler Echocardiography procedure is not allowed on same date of service, by the same or different provider when in conjunction with echocardiography procedure.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
2864	**Claim denied. Only one epogen administration allowed per day. Service has previously been billed for this date, same or different provider**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
2864	**Claim denied. Only one epogen administration allowed per day. Service has previously been billed for this date, same or different provider**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
2892	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.

2893	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
2896	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
2896	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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
2899	**RC452 not allowed without corresponding RC451.**	**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.	**258**	Days-units for procedure-revenue code.
2899	**RC452 not allowed without corresponding RC451.**	**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.	**258**	Days-units for procedure-revenue code.

2750	**Procedure/modifier combination not allowed same day when billed by DME provider and paid to CAP provider.**	**125**	Submission-billing error(s)	**M86**	Service denied because payment already made for similar/same procedure within set timeframe.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2750	**Procedure/modifier combination not allowed same day when billed by DME provider and paid to CAP provider.**	**125**	Submission-billing error(s)	**N20**	Service not payable with other service rendered on the same date.	**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	**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.
2906	**The claim pregnancy indicator must be numeric value and it must be one of the following: 0, 1 or 2.**	**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.

2907	**The claim other-coverage-code field must be numeric value, and it must be one of the following: 01, 02, 03, 04 or 07.**	**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.
2908	**Maximum days supply or daily dosage was exceeded. Verify and resubmit. For POS claims override with a '2' in the PAMC field. Questions, Call 1-800-688-6696.**	**154**	Payer deems the information submitted does not support this days supply	**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.
2911	**POS - invalid transaction code. 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.
2912	**POS - bin error. Correct 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.
2913	**POS - processor control number not certified to submit 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.

2914	**POS - invalid quantity. Correct quantity to numeric value 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.
2915	**POS - dispense as written value invalid. Correct 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.
2916	**POS - new-refill code not numeric. Correct 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.
2917	**POS - ucc amount must be numeric and greater than zero. Correct 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.
2917	**POS - ucc amount must be numeric and greater than zero. Correct 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.	**402**	Amount must be greater than zero.

2918	**POS - invalid value for compound code. Correct 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.
2919	**POS - invalid pa-mc code. Correct 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.
2920	**POS - level of service invalid. Correct 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.
2921	**POS - unit dose indicator invalid. Correct 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.
2922	**POS - prescription date invalid. Correct and resubmit in ccyymmdd format.**	**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.

2923	**POS - gross amount invalid (must be numeric and greater than zero). Correct 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.
2923	**POS - gross amount invalid (must be numeric and greater than zero). Correct 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.	**402**	Amount must be greater than zero.
2924	**POS - other payer amount invalid (data must be numeric). Correct and resubmit.**	**148**	Information from another provider was not provided or was insufficient-incomplete	**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.
2925	**POS - DUR conflict code invalid. Correct 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.
2926	**POS - DUR intervention code invalid. Correct 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.

2927	**POS - DUR outcome code invalid. Correct 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.
2928	**POS - patient pay amount invalid. Data must be numeric. Correct 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.
2929	**Point-of-Sale agreement not on file.**	**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.
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.
2931	**POS - days supply must be numeric and greater than zero**	**154**	Payer deems the information submitted does not support this days supply	**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.

2931	**POS - days supply must be numeric and greater than zero**	**154**	Payer deems the information submitted does not support this days supply	**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.	**402**	Amount must be greater than zero.
2944	**90782 is covered for use w evocative-suppression tests only. Use appropriate HCPC to bill for therapeutic and-or diagnostic injection.**	**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.	**454**	Procedure code for services rendered.
2944	**90782 is covered for use w evocative-suppression tests only. Use appropriate HCPC to bill for therapeutic and-or diagnostic injection.**	**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.	**454**	Procedure code for services rendered.
2950	**Prescriber DEA or NPI on claim is missing. Refile with correct DEA or NPI.**	**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.
2950	**Prescriber DEA or NPI on claim is missing. Refile with correct DEA or NPI.**	**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.	**562**	Entitys National Provider Identifier (NPI).

2951	**DEA on claim not a valid DEA. Contact prescriber and refile with correct DEA.**	**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.
2952	**Prescriber DEA number or NPI is not in the proper format. Please refile claim with correct DEA or NPI.**	**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.
2952	**Prescriber DEA number or NPI is not in the proper format. Please refile claim with correct DEA or NPI.**	**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.	**562**	Entitys National Provider Identifier (NPI).
2954	**Reimbursement was made on previously paid detail. Payment is determined by # of automated tests billed. Payment and # of units are reflected on 1st detail.**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
2955	**Payment reduced to equal the number of automated lab tests billed for this recipient. Additional payment was made on a previously paid detail.**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M75**	Multiple automated multichannel tests performed on the same day combined for payment.	**300**	Lab-test report-notes-results.

2955	**Payment reduced to equal the number of automated lab tests billed for this recipient. Additional payment was made on a previously paid detail.**	**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	**300**	Lab-test report-notes-results.
2955	**Payment reduced to equal the number of automated lab tests billed for this recipient. Additional payment was made on a previously paid detail.**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M75**	Multiple automated multichannel tests performed on the same day combined for payment.	**483**	Maximum coverage amount met or exceeded for benefit period.
2955	**Payment reduced to equal the number of automated lab tests billed for this recipient. Additional payment was made on a previously paid detail.**	**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	**483**	Maximum coverage amount met or exceeded for benefit period.
2956	**No additional payment due for this individual lab code. Maximum reimbursement for the total number of tests has been made on previous claim(s).**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M126**	Missing-incomplete-invalid individual lab codes included in the test.	**300**	Lab-test report-notes-results.
2956	**No additional payment due for this individual lab code. Maximum reimbursement for the total number of tests has been made on previous claim(s).**	**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	**300**	Lab-test report-notes-results.
2956	**No additional payment due for this individual lab code. Maximum reimbursement for the total number of tests has been made on previous claim(s).**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M126**	Missing-incomplete-invalid individual lab codes included in the test.	**483**	Maximum coverage amount met or exceeded for benefit period.
2956	**No additional payment due for this individual lab code. Maximum reimbursement for the total number of tests has been made on previous claim(s).**	**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	**483**	Maximum coverage amount met or exceeded for benefit period.

2960	**Missing or invalid Compound Ingredient NDC**	**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.
2961	**Missing or invalid Segment Identification**	**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.
2962	**Missing or invalid Prescription Number Qualifier only a value of '1' is accepted.**	**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.
2963	**Missing or invalid Product ID Qualifier, only a NDC Qualifier Code of '03' is accepted.**	**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.
2964	**Missing or invalid Prior Authorization Type 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.
2965	**Partial Fill- Completion Fill Transactions Not Supported.**	**B5**	Coverage-program guidelines were not met or were exceeded.		**No Mapping Required**	**107**	Processed according to contract-plan provisions.

2966	**Missing or invalid Prescriber ID Qualifier. The Valid Qualifier is 12.**	**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.
2967	**Only a value of 1, 2, or 3 can be submitted for coordination of benefits-other payments count.**	**148**	Information from another provider was not provided or was insufficient-incomplete	**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.
2968	**Invalid Other Payer Coverage Type 01, 02, 03, 98 or 99 are the only valid types accepted**	**148**	Information from another provider was not provided or was insufficient-incomplete	**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.
2969	**Invalid Other Payer Amount Count. Other Payer Amount Count must be a numeric value between 1 and 9**	**148**	Information from another provider was not provided or was insufficient-incomplete	**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.
2970	**Missing or invalid Other Payer Amount Paid Qualifier. Must be 01 through 08, 98, 99 or blank**	**148**	Information from another provider was not provided or was insufficient-incomplete	**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.
2971	**Pharmacy claim must be filed with POS.**	**125**	Submission-billing error(s)	**M117**	Not covered unless submitted via electronic claim	**481**	Claim-submission format is invalid.

2975	**Invalid Claim Count for Claim Type or Claim Count indicated in Header does not match actual number of claims submitted**	**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.
2976	**M-I Compound Ingredient Quantity**	**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.
2977	**M-I Compound Product ID Qualifier, only a NDC Qualifier Code of '3' is accepted**	**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.
2978	**M-I Compound Ingredient Cost**	**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.
2979	**Actual Compound Ingredient doesn't match Ingredient Count submitted on 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.
2980	**Compound Rebill Drug Claims must be submitted through POS**	**125**	Submission-billing error(s)	**M117**	Not covered unless submitted via electronic claim	**481**	Claim-submission format is invalid.

2981	**Compound Ingredient Count must be greater than '0' and less than '26'**	**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.
2981	**Compound Ingredient Count must be greater than '0' and less than '26'**	**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.	**402**	Amount must be greater than zero.
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.
2987	**Dispensing of Depo-Provera is limited to once per 3 months.**	**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.
2987	**Dispensing of Depo-Provera is limited to once per 3 months.**	**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.
2988	**Anesthesia services must be appended with modifiers AA, QK, QX, QY, or QZ**	**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
2989	**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.
2989	**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
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
2999	**RC 599 and RC679 not allowed on same date of service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
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.
3001	**RC and-or HCPC code is missing and-or is an invalid combination. Refer to your 1995 manual for the correct billing instructions. Correct 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.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3002	**Claim does not support medical necessity, claim must have appropriate condition codes to describe the patient's qualifying criteria and level of service.**	**50**	These are non-covered services because this is not deemed a `medical necessity by the payer.	**N29**	Missing-incomplete-invalid documentation-orders-notes-summary-report-chart.	**431**	Provide condition-functional status at time of service.
3002	**Claim does not support medical necessity, claim must have appropriate condition codes to describe the patient's qualifying criteria and level of service.**	**50**	These are non-covered services because this is not deemed a `medical necessity by the payer.	**N163**	Medical Record does not support code billed per the code definition.	**431**	Provide condition-functional status at time of service.
3002	**Claim does not support medical necessity, claim must have appropriate condition codes to describe the patient's qualifying criteria and level of service.**	**50**	These are non-covered services because this is not deemed a `medical necessity by the payer.	**N180**	This item or service does not meet the criteria for the category under which it was billed	**431**	Provide condition-functional status at time of service.

3002	**Claim does not support medical necessity, claim must have appropriate condition codes to describe the patient's qualifying criteria and level of service.**	**50**	These are non-covered services because this is not deemed a `medical necessity by the payer.	**N29**	Missing-incomplete-invalid documentation-orders-notes-summary-report-chart.	**460**	NUBC Condition Code(s)
3002	**Claim does not support medical necessity, claim must have appropriate condition codes to describe the patient's qualifying criteria and level of service.**	**50**	These are non-covered services because this is not deemed a `medical necessity by the payer.	**N163**	Medical Record does not support code billed per the code definition.	**460**	NUBC Condition Code(s)
3002	**Claim does not support medical necessity, claim must have appropriate condition codes to describe the patient's qualifying criteria and level of service.**	**50**	These are non-covered services because this is not deemed a `medical necessity by the payer.	**N180**	This item or service does not meet the criteria for the category under which it was billed	**460**	NUBC Condition Code(s)
3003	**RC634 must be billed with an appropriate HCPC code. HCPC code is 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.
3004	**Refile claim as an adj w documentation to support med necessity.**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-incomplete-invalid documentation-orders-notes-summary-report-chart.	**294**	Supporting documentation.
3007	**Patient facility ID is missing, invalid, or unresolved. Verify patient facility ID and resubmit as new claim or contact HP Provider Services if ID is correct**	**A1**	Claim-Service denied	**MA134**	Missing-incomplete-invalid provider number of the facility where the patient resides.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

3007	**Patient facility ID is missing, invalid, or unresolved. Verify patient facility ID and resubmit as 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.
3007	**Patient facility ID is missing, invalid, or unresolved. Verify patient facility ID and resubmit as new claim or contact HP Provider Services if ID is correct**	**A1**	Claim-Service denied	**MA134**	Missing-incomplete-invalid provider number of the facility where the patient resides.	**562**	Entitys National Provider Identifier (NPI)
3007	**Patient facility ID is missing, invalid, or unresolved. Verify patient facility ID and resubmit as new claim or contact HP Provider Services if ID is correct**	**A1**	Claim-Service denied	**N253**	Missing-incomplete-invalid attending provider primary identifier.	**562**	Entitys National Provider Identifier (NPI)
3010	**RC780 must be billed with the appropriate procedure code for TELECONSULT services. Procedure code is 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.
3011	**Add-on code must be billed with a paid primary procedure for reimbursement.**	**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.	**454**	Procedure code for services rendered.
3011	**Add-on code must be billed with a paid primary procedure for reimbursement.**	**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.	**454**	Procedure code for services rendered.

3012	**Add-on code must be billed with a paid 'Primary' procedure in series for reimbursement.**	**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.	**454**	Procedure code for services rendered.
3012	**Add-on code must be billed with a paid 'Primary' procedure in series for reimbursement.**	**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.	**454**	Procedure code for services rendered.
3013	**Add-on code must be billed with a paid 'Primary' procedure in series for reimbursement.**	**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.	**454**	Procedure code for services rendered.
3013	**Add-on code must be billed with a paid 'Primary' procedure in series for reimbursement.**	**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.	**454**	Procedure code for services rendered.
3014	**Add-on code must be billed with a paid 'Primary' procedure in series for reimbursement.**	**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.	**454**	Procedure code for services rendered.
3014	**Add-on code must be billed with a paid 'Primary' procedure in series for reimbursement.**	**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.	**454**	Procedure code for services rendered.

3015	**Simple and complex repair for resection of diaphragm not allowed on same date of service.**	**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.
3016	**Only one appendectomy procedure allowed.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N117**	This service is paid only once in a patients lifetime.	**259**	Frequency of service.
3017	**Only one laparoscopy procedure allowed per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
3017	**Only one laparoscopy procedure allowed per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
3018	**Multiple inguinal hernia repairs not allowed on the same date of service.**	**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.

3019	**Multiple recurrent inguinal hernia repairs not allowed on the same date of service.**	**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.
3020	**Multiple procedures related to renal cysts not allowed on same date of service.**	**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.
3021	**Related pyeloplasty procedures not allowed same date of service.**	**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.

3022	**Related donor Nephrectomy procedure not allowed same date of service.**	**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.
3023	**Related nephrectomy procedures not allowed on same date of service.**	**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.
3024	**Related nephroureterectomy procedure not allowed same date of service.**	**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.

3025	**Related ureterolithotomy procedure not allowed on same date of service.**	**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.
3026	**Related sling operation for stress incontinence not allowed on same date of service.**	**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.
3027	**Related orchiopexy procedure not allowed on same date of service.**	**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.

3028	**Related male genital procedure not allowed on same date of service.**	**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.
3029	**Related spermatic procedure not allowed on same date of service.**	**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.
3030	**Related male genital procedure not allowed on same date of service.**	**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.

3031	**Related vaginal hysterectomy procedure not allowed on same date of service.**	**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.
3032	**Related cranial neurostimulator procedure not allowed on same date of service.**	**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.
3033	**Add-on code must be billed with a paid 'primary' procedure in series for reimbursement.**	**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.	**454**	Procedure code for services rendered.
3033	**Add-on code must be billed with a paid 'primary' procedure in series for reimbursement.**	**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.	**454**	Procedure code for services rendered.
3034	**Cervical or thoracic injection limited to 18 per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

3034	**Cervical or thoracic injection limited to 18 per date of service.**	**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.
3034	**Cervical or thoracic injection limited to 18 per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
3034	**Cervical or thoracic injection limited to 18 per date of service.**	**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	**612**	Per Day Limit Amount
3035	**Add-on code must be billed with a paid 'primary' procedure in**	**107**	The related or qualifying claim-service was not identified on this	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
					between this service-procedure-		

3036	**Lumbar or sacral injection limited to 5 per date of service.**	**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	**612**	Per Day Limit Amount
3037	**Add-on code must be billed with a paid 'primary' procedure in series for reimbursement.**	**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.	**454**	Procedure code for services rendered.
3037	**Add-on code must be billed with a paid 'primary' procedure in series for reimbursement.**	**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.	**454**	Procedure code for services rendered.
3039	**Add-on code must be billed with a paid 'primary' procedure in series for reimbursement.**	**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.	**454**	Procedure code for services rendered.
3039	**Add-on code must be billed with a paid 'primary' procedure in series for reimbursement.**	**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.	**454**	Procedure code for services rendered.
3041	**Add-on code must be billed with a paid 'primary' procedure in series for reimbursement.**	**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.	**454**	Procedure code for services rendered.

3041	**Add-on code must be billed with a paid 'primary' procedure in series for reimbursement.**	**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.	**454**	Procedure code for services rendered.
3042	**Procedure limited to 18 per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
3042	**Procedure limited to 18 per date of service.**	**119**	Benefit maximum for this time period or occurrence has been	**N357**	Time frame requirements between this service-procedure-	**259**	Frequency of service.
					between this service-procedure-		

3044	**Components of renal function panel recouped to allow reimbursement of 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.
3045	**Components of renal function panel included in reimbursement of 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.
3046	**Related cardioversion procedure not allowed on same date of service.**	**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.
3047	**Internal and external cardioversion procedure not allowed on same date of service.**	**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.

3048	**Related cardiac recorder procedure not allowed on same date of service.**	**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.
3049	**Component of this procedure denied. This procedure already reimbursed as a complete procedure on the same date of 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.
3050	**Complete procedure denied. Technical component of this procedure already reimbursed for the same date of 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.
3051	**Complete procedure denied. Professional component of this procedure already reimbursed for the same date of 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.

3052	**Component of hepatic function panel recouped to allow reimbursement of 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.
3053	**Component of hepatic function panel included in reimbursement of 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.
3054	**Adjustment denied. Unrelated-non-covered services cannot be combined.**	**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.
3054	**Adjustment denied. Unrelated-non-covered services cannot be combined.**	**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.	**178**	Submitted charges.
3066	**Procedure must be billed with the required E&M or administration procedure code, by the same attending provider**	**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.	**MA66**	Missing-incomplete-invalid principal procedure code.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

3066	**Procedure must be billed with the required E&M or administration procedure code, by the same attending provider**	**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.	**MA66**	Missing-incomplete-invalid principal procedure code.	**465**	Principal Procedure Code for Service(s) Rendered
3066	**Procedure must be billed with the required E&M or administration procedure code, by the same attending provider**	**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).	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3066	**Procedure must be billed with the required E&M or administration procedure code, by the same attending provider**	**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
3073	**Levulan derastick, 1 stick equals 1 unit. Medicaid allows 2 units within 8 weeks**	**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.
3073	**Levulan derastick, 1 stick equals 1 unit. Medicaid allows 2 units within 8 weeks**	**119**	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.

3073	**Levulan derastick, 1 stick equals 1 unit. Medicaid allows 2 units within 8 weeks**	**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
3073	**Levulan derastick, 1 stick equals 1 unit. Medicaid allows 2 units within 8 weeks**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**483**	Maximum coverage amount met or exceeded for benefit period
3074	**Levulan kerastick not allowed unless procedure 96567 is paid. Please bill J7308 with procedure 96567**	**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**	This drug-service-supply is covered only when the associated service is covered.	**454**	Procedure code for services rendered.
3074	**Levulan kerastick not allowed unless procedure 96567 is paid. Please bill J7308 with procedure 96567**	**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**	Procedure code incidental to primary procedure	**454**	Procedure code for services rendered.
3074	**Levulan kerastick not allowed unless procedure 96567 is paid. Please bill J7308 with procedure 96567**	**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**	This drug-service-supply is covered only when the associated service is covered.	**465**	Principal Procedure Code for Service(s) Rendered
3074	**Levulan kerastick not allowed unless procedure 96567 is paid. Please bill J7308 with procedure 96567**	**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**	Procedure code incidental to primary procedure	**465**	Principal Procedure Code for Service(s) Rendered
3079	**Adult Care Home Transition procedure not allowed on the same date of service as Personal Care Services already paid to the same or different provider**	**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

3080	**Personal Care Service procedure not allowed on the same date of service as Adult Care Home Transition procedure already paid to the same or different provider**	**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
3085	**Procedure limitation exceeded per day. Units cutback to allowed amount**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M53**	Missing-incomplete-invalid days or units of service.	**259**	Frequency of service.
3085	**Procedure limitation exceeded per day. Units cutback to allowed amount**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M53**	Missing-incomplete-invalid days or units of service.	**454**	Procedure code for services rendered.
3085	**Procedure limitation exceeded per day. Units cutback to allowed amount**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M53**	Missing-incomplete-invalid days or units of service.	**612**	Per Day Limit Amount
3087	**Molecular diagnosis add on must be billed with pirmary procedure.**	**125**	Submission-billing error(s)	**M51**	Missing-incomplete-invalid procedure code(s).	**259**	Frequency of service.
3087	**Molecular diagnosis add on must be billed with pirmary procedure.**	**125**	Submission-billing error(s)	**M51**	Missing-incomplete-invalid procedure code(s).	**454**	Procedure code for services rendered.
3088	**Auditory Pre-Lingual hearing loss not allowed with Post-Lingual hearing loss procedure**	**125**	Submission-billing error(s)	**M51**	Missing-incomplete-invalid procedure code(s).	**259**	259 - Frequency of service.
3088	**Auditory Pre-Lingual hearing loss not allowed with Post-Lingual hearing loss procedure**	**125**	Submission-billing error(s)	**M51**	Missing-incomplete-invalid procedure code(s).	**454**	Procedure code for services rendered.
3088	**Auditory Pre-Lingual hearing loss not allowed with Post-Lingual hearing loss procedure**	**125**	Submission-billing error(s)	**M51**	Missing-incomplete-invalid procedure code(s).	**459**	Lifetime Reserve Day(s)
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)
3105	**The National Provider Identifier submitted for the prescribing provider is missing or invalid**	**A1**	Claim-Service denied	**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.
3105	**The National Provider Identifier submitted for the prescribing provider is missing or invalid**	**A1**	Claim-Service denied	**N31**	Missing-incomplete-invalid prescribing provider identifier	**562**	Entitys National Provider Identifier (NPI)
3106	**The National Provider Identifier submitted for the prescribing provider cannot be the same as the Pharmacy's National Provider Identifier**	**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.
3106	**The National Provider Identifier submitted for the prescribing provider cannot be the same as the Pharmacy's National Provider Identifier**	**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)

3108	**Exceeds number of units allowed per 84 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
3109	**Units cutback. Number of units allowed per 84 days exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code
3110	**Supply of imaging agent not w-provision of diagnostic radiopharmaceutical.**	**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
3111	**Provision of diagnostic radiopharmaceutical not allowed with related supply of imaging agent.**	**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
3112	**Supply of injectable contrast material for use in echocardiography, requires echocardiography procedure on the same day.**	**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.	**258**	Days-units for procedure-revenue code
3112	**Supply of injectable contrast material for use in echocardiography, requires echocardiography procedure on the same day.**	**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.	**258**	Days-units for procedure-revenue code

3115	**Type of bill used on claim has been labeled reserved.**	**125**	Submission-billing error(s)	**MA30**	Missing-incomplete-invalid type of bill.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3115	**Type of bill used on claim has been labeled reserved.**	**125**	Submission-billing error(s)	**MA30**	Missing-incomplete-invalid type of bill.	**228**	Type of bill for UB claim.
3116	**Revenue code billed has been labeled as reserved**	**125**	Submission-billing error(s)	**MA30**	Missing-incomplete-invalid type of bill.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3116	**Revenue code billed has been labeled as reserved**	**125**	Submission-billing error(s)	**MA30**	Missing-incomplete-invalid type of bill.	**228**	Type of bill for UB claim.
3117	**Point of origin is invalid**	**125**	Submission-billing error(s)	**MA30**	Missing-incomplete-invalid type of bill.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3117	**Point of origin is invalid**	**125**	Submission-billing error(s)	**MA30**	Missing-incomplete-invalid type of bill.	**228**	Type of bill for UB claim.
3118	**Procedure limited to 230 per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
3118	**Procedure limited to 230 per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
3118	**Procedure limited to 230 per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**483**	Maximum coverage amount met or exceeded for benefit period.
3118	**Procedure limited to 230 per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
3119	**High tech image and ultrasound same RC/ Same CPT not allowed same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.

3119	**High tech image and ultrasound same RC/ Same CPT not allowed same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
3119	**High tech image and ultrasound same RC/ Same CPT not allowed same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
3119	**High tech image and ultrasound same RC/ Same CPT not allowed same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
3120	**Previously billed proc. Performed during the f-u of another requires a modifier. If current claim is original procedure, request recoupment of paid detail and resubmit with modifier.**	**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.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3121	**Cutback exceeds the allowable 230 per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
3121	**Cutback exceeds the allowable 230 per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service
3122	**Maximum units per year for this procedure have been paid by same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service
3125	**Mental health/substance abuse targeted case management not allowed with related behavioral health services procedures for the same calendar week by same or different provider**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

3125	**Mental health/substance abuse targeted case management not allowed with related behavioral health services procedures for the same calendar week by same or different provider**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**187**	Date(s) of service.
3125	**Mental health/substance abuse targeted case management not allowed with related behavioral health services procedures for the same calendar week by same or different provider**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
3125	**Mental health/substance abuse targeted case management not allowed with related behavioral**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-	**454**	Procedure code for services rendered.
					between this service-procedure-		

3126	**Behavioral health services not allowed with other related mental health/substance abuse targeted case management procedures for same calendar week by same/different 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
3126	**Behavioral health services not allowed with other related mental health/substance abuse targeted case management procedures for same calendar week by same/different provider**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
3134	**Add-on code not allowed unless primary procedure paid in history for same date of service, by the same or different provider**	**A1**	Claim-Service denied	**M51**	Missing-incomplete-invalid procedure code(s).	**465**	Principal Procedure Code for Service(s) Rendered
3134	**Add-on code not allowed unless primary procedure paid in history for same date of service, by the same or different provider**	**A1**	Claim-Service denied	**N301**	Missing-incomplete-invalid procedure date(s).	**465**	Principal Procedure Code for Service(s) Rendered
3150	**Only one ACH Transition payment procedure allowed per same date of service by the same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**259**	Frequency of service
3162	**Drug limited to 1800 units per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**258**	Days-units for procedure-revenue code.
3162	**Drug limited to 1800 units per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**259**	Frequency of service

3163	**Behavioral health service not allowed on same date of service as realated service performed by same attending provider**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
3164	**Behavioral health HCPCS code not allowed on same date of service as realated cpt code paid to the same attending provider**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
3170	**Cpt code not allowed same date of service as related Behavioral health HCPCS code paid for same date of service to same attending provider**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
3183	**RC450 not allowed same day, same hour as RC451 or RC452.**	**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.
3184	**RC451 and RC452 not allowed same day, same hour as RC450.**	**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.
3195	**Claim denied. Essure follow up guidelines not met**	**A1**	Claim-Service denied	**M16**	**Alert:** Please see our website, mailings, or bulletins for more details concerning this policy procedure decision	**259**	Frequency of service

3196	**Procedure/modifier combination with this diagnosis is allowed only once per lifetime**	**149**	Lifetime benefit maximum has been reached for this service-benefit category	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
3196	**Procedure/modifier combination with this diagnosis is allowed only 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.
3196	**Procedure/modifier combination with this diagnosis is allowed only once per lifetime**	**149**	Lifetime benefit maximum has been reached for this service-benefit category	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**488**	Diagnosis code(s) for the service rendered
3196	**Procedure/modifier combination with this diagnosis is allowed only 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.	**488**	Diagnosis code(s) for the service rendered
3197	**Other sterilization procedure is not allowed when Essure procedure is paid in history for this recipient**	**119**	Benefit maximum for this time period or occurrence has been reached	**M79**	Missing-incomplete-invalid charge.	**259**	Frequency of service.
3197	**Other sterilization procedure is not allowed when Essure procedure is paid in history for this recipient**	**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.
3197	**Other sterilization procedure is not allowed when Essure procedure is paid in history for this recipient**	**119**	Benefit maximum for this time period or occurrence has been reached	**M79**	Missing-incomplete-invalid charge.	**454**	Procedure code for service rendered.
3197	**Other sterilization procedure is not allowed when Essure procedure is paid in history for this recipient**	**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 service rendered.
3197	**Other sterilization procedure is not allowed when Essure procedure is paid in history for this recipient**	**119**	Benefit maximum for this time period or occurrence has been reached	**M79**	Missing-incomplete-invalid charge.	**492**	Other procedure date

3197	**Other sterilization procedure is not allowed when Essure procedure is paid in history for this recipient**	**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	**492**	Other procedure date
3198	**Resubmit as an adjustment with medical records or if Essure is the procedure billed, diagnosis code v25.2 must be in primary or secondary diagnosis field.**	**A1**	Claim-Service denied	**M29**	Missing operative report.	**255**	Diagnosis code.
3198	**Resubmit as an adjustment with medical records or if Essure is the procedure billed, diagnosis code v25.2 must be in primary or secondary diagnosis field.**	**A1**	Claim-Service denied	**N29**	Missing documentation-orders-notes-summary-report-chart	**255**	Diagnosis code.
3198	**Resubmit as an adjustment with medical records or if Essure is the procedure billed, diagnosis code v25.2 must be in primary or secondary diagnosis field.**	**A1**	Claim-Service denied	**M29**	Missing operative report.	**297**	Medical notes-report.
3198	**Resubmit as an adjustment with medical records or if Essure is the procedure billed, diagnosis code v25.2 must be in primary or secondary diagnosis field.**	**A1**	Claim-Service denied	**N29**	Missing documentation-orders-notes-summary-report-chart	**297**	Medical notes-report.
3198	**Resubmit as an adjustment with medical records or if Essure is the procedure billed, diagnosis code v25.2 must be in primary or secondary diagnosis field.**	**A1**	Claim-Service denied	**M29**	Missing operative report.	**298**	Operative report
3198	**Resubmit as an adjustment with medical records or if Essure is the procedure billed, diagnosis code v25.2 must be in primary or secondary diagnosis field.**	**A1**	Claim-Service denied	**N29**	Missing documentation-orders-notes-summary-report-chart	**298**	Operative report

3199	**Requested units exceeded for this drug per month. Prior approval is required. Prescriber please call ACS: 1-866-246-8505**	**197**	Precertification-authorization-notification absent.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code.
3200	**Requested units exceeded for this drug per month.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code.
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.
3215	**Units cutback. Maximum number of units per year exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
3215	**Units cutback. Maximum number of units per year exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.

3215	**Units cutback. Maximum number of units per year exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
3215	**Units cutback. Maximum number of units per year exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
3234	**This recipient not authorized for high risk intervention.**	**30**	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	**N30**	Patient ineligible for this service.	**91**	Entity not eligible-not approved for dates of service.
3235	**This HRI-RM not authorized to receive HRI payment for this recipient for DOS billed.**	**30**	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	**N30**	Patient ineligible for this service.	**91**	Entity not eligible-not approved for dates of service.
3236	**This recipient not authorized for high risk intervention.**	**30**	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	**M83**	Service is not covered unless the patient is classified as at high risk.	**91**	Entity not eligible-not approved for dates of service.
3237	**This HRI-RM not authorized to receive HRI payment for this recipient for DOS billed.**	**30**	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	**M83**	Service is not covered unless the patient is classified as at high risk.	**91**	Entity not eligible-not approved for dates of service.
3239	**This hospice provider not authorized to received hospice payment for this recipient on date of service.**	**52**	The referring-prescribing-rendering provider is not eligible to refer-prescribe-order-perform the service billed.	**N95**	This provider type - provider specialty may not bill this service.	**91**	Entity not eligible-not approved for dates of service.
3240	**HP has not been notified of hospice election for this date of service.**	**30**	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	**N30**	Patient ineligible for this service.	**91**	Entity not eligible-not approved for dates of service.
3241	**HP has not been notified of hospice election for this recipient.**	**30**	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	**N30**	Patient ineligible for this service.	**91**	Entity not eligible-not approved for dates of service.

3269	**Therapeutic, prophylactic or diagnostic injection must be billed with the primary procedure code by the same provider.**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3270	**Therapeutic, prophylactic or diagnostic injection must be billed with a related radiopharmaceutical code by the same provider.**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3300	**Procedure cutback. Limited to 1 per instance of breast cancer**	**119**	Benefit maximum for this time period or occurrence has been	**M86**	Service denied because payment already made for	**259**	Frequency of service.
					between this service-procedure-		

3305	**Number of units on claim believed to contain typographical error. If units of Q4081 are correct, send medical records and adjustment request for consideration of additional units**	**A1**	Claim-Service denied	**N115**	This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD). An LMRP-LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http--- www.cms.hhs.gov-mcd, or if you do not have web access, you may contact the contractor to request a copy of the LMRP-LCD.	**287**	Medical necessity for service.
3305	**Number of units on claim believed to contain typographical error. If units of Q4081 are correct, send medical records and adjustment request for consideration of additional units**	**A1**	Claim-Service denied	**M53**	Missing-incomplete-invalid days or units of service.	**317**	Patients medical records.
3305	**Number of units on claim believed to contain typographical error. If units of Q4081 are correct, send medical records and adjustment request for consideration of additional units**	**A1**	Claim-Service denied	**N115**	This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD). An LMRP-LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http--- www.cms.hhs.gov-mcd, or if you do not have web access, you may contact the contractor to request a copy of the LMRP-LCD.	**317**	Patients medical records.

3325	**Delivery of placenta, external cephalic version or special miscellaneous services included in fee for delivery**	**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.	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**585**	Denied Charge or Non-covered Charge
3325	**Delivery of placenta, external cephalic version or special miscellaneous services included in fee for delivery**	**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.	**N19**	Procedure code incidental to primary procedure.	**585**	Denied Charge or Non-covered Charge
3332	**School based health center's sponsoring provider is not eligible. Please contact DWCH for more information.**	**52**	The referring-prescribing-rendering provider is not eligible to refer-prescribe-order-perform the service billed.	**N95**	This provider type - provider specialty may not bill this service.	**109**	Entity not eligible. Note- This code requires use of an Entity Code.
3392	**Claim denied. Respiratory therapy in a school setting limited to 2 dates of service per recipient per 365 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.
3395	**Code allowed once per gentational period**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
3397	**Service denied. The procedure billed is only payable to a pregnancy medical home (PMH) provider**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	**585**	Denied Charge or Non-covered Charge
3398	**PMH initial assessment and PMH post partum assessment, not allowed same day, same or different provider**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**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	**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
3425	**Community support not allowed same calendar week as MH/SA TCM**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
3425	**Community support not allowed same calendar week as MH/SA TCM**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**187**	Date(s) of service.
3425	**Community support not allowed same calendar week as MH/SA TCM**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
3425	**Community support not allowed**	**A1**	Claim-Service denied	**N357**	Time frame requirements	**453**	Procedure Code Modifier(s) for
					between this service-procedure-		

3453	**Procedure code not allowed for place of service billed, if 60 days has expired from when MH/SA TCM service was rendered**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**249**	Place of service.
3453	**Procedure code not allowed for place of service billed, if 60 days has expired from when MH/SA TCM service was rendered**	**A1**	Claim-Service denied	**N428**	Service-procedure not covered when performed in this place of service.	**249**	Place of service.
3453	**Procedure code not allowed for place of service billed, if 60 days has expired from when MH/SA TCM service was rendered**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**454**	Procedure code for services rendered.
3453	**Procedure code not allowed for place of service billed, if 60 days has expired from when MH/SA TCM service was rendered**	**A1**	Claim-Service denied	**N428**	Service-procedure not covered when performed in this place of service.	**454**	Procedure code for services rendered.
3505	**Units billed for Epogen procedure for the calendar month have been exceeded. An adjustment request including medical records is required for consideration of additional units**	**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.
3506	**Epogen services are limited to 13 occurrences per this calendar month. An Adjustment Request including medical records is required for review of additional occurrences**	**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.
3507	**Units billed for Epogen procedure have been cutback to the maximum allowable units**	**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.

3508	**Units billed for Epogen procedure have been cutback to the maximum allowable units**	**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.
3509	**Epogen procedures are specific to units billed. Correct claim if necessary to combine units under one appropriate procedure and file as an adjustment**	**A1**	Claim-Service denied	**M50**	Missing-incomplete-invalid revenue code(s).	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3509	**Epogen procedures are specific to units billed. Correct claim if necessary to combine units under one appropriate procedure and file as an adjustment**	**A1**	Claim-Service denied	**M50**	Missing-incomplete-invalid revenue code(s).	**476**	Missing or invalid units of service
3510	**Units billed for Epogen procedure for calendar month have been exceeded. An adjustment request including medical records is required for consideration of additional units**	**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.
3511	**Service Rendered in facility this date of service. Physician charge not allowed**	**B20**	Procedure-service was partially or fully furnished by another provider.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service. .
3511	**Service Rendered in facility this date of service. Physician charge not allowed**	**B20**	Procedure-service was partially or fully furnished by another provider.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
3511	**Service Rendered in facility this date of service. Physician charge not allowed**	**B20**	Procedure-service was partially or fully furnished by another provider.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
3511	**Service Rendered in facility this date of service. Physician charge not allowed**	**B20**	Procedure-service was partially or fully furnished by another provider.	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.

3512	**Outpt. Provider - 196 unit limit exceeded. Place billed amount for units over 196 in non-covered section of claim or file adjustment with records to support additional units**	**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.
3550	**Safety documentation requested. Prescriber call ACS 866-246-8505**	**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.	**N29**	Missing documentation-orders-notes-summary-report-chart.	**294**	Supporting documentation. Note: At least one other status code is required to identify the supporting documentation.
3550	**Safety documentation requested. Prescriber call ACS 866-246-8505**	**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.	**N29**	Missing documentation-orders-notes-summary-report-chart.	**297**	Medical notes-report.
3585	**Drug therapy procedure(s) not allowed unless billed in addition to HIT Nursing Service procedure**	**A1**	Claim-Service denied	**M51**	Missing-incomplete-invalid procedure code(s).	**454**	Procedure code for services rendered.
3585	**Drug therapy procedure(s) not allowed unless billed in addition to HIT Nursing Service procedure**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3585	**Drug therapy procedure(s) not allowed unless billed in addition to HIT Nursing Service procedure**	**A1**	Claim-Service denied	**N161**	This drug-service-supply is covered only when the associated service is covered.	**454**	Procedure code for services rendered.
3626	**Community support recouped, not allowed same calendar week as MH/SA TCM**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.

3626	**Community support recouped, not allowed same calendar week as MH/SA TCM**	**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.	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**187**	Date(s) of service.
3626	**Community support recouped, not allowed same calendar week as MH/SA TCM**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
3626	**Community support recouped, not allowed same calendar week as MH/SA TCM**	**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.	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
3700	**Epidermal autograft must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3700	**Epidermal autograft must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.
3701	**Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3701	**Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.

3702	**Dermal autograft, trunk, arms, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3702	**Dermal autograft, trunk, arms, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.
3703	**Dermal autograft, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3703	**Dermal autograft, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.
3704	**Tissue cultured epidermal autograft, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3704	**Tissue cultured epidermal autograft, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.
3705	**Tissue cultured epidermal autograft, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3705	**Tissue cultured epidermal autograft, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.
3706	**Tissue cultured epidermal autograft, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3706	**Tissue cultured epidermal autograft, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.

3707	**Tissue cultured epidermal autograft, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3707	**Tissue cultured epidermal autograft, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.
3708	**Acellular dermal replacement, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3708	**Acellular dermal replacement, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.
3709	**Acellular dermal replacement, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3709	**Acellular dermal replacement, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.
3710	**Allograft skin for temporary wound closure, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3710	**Allograft skin for temporary wound closure, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.
3711	**Allograft skin for temporary wound closure, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.

3711	**Allograft skin for temporary wound closure, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.
3712	**Acellular dermal allograft, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3712	**Acellular dermal allograft, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.
3713	**Acellular dermal allograft, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3713	**Acellular dermal allograft, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.
3714	**Tissue cultured allogeneic skin substitute, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3714	**Tissue cultured allogeneic skin substitute, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.
3715	**Tissue cultured allogeneic dermal substitute, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3715	**Tissue cultured allogeneic dermal substitute, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.

3716	**Tissue cultured allogeneic dermal substitute, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3716	**Tissue cultured allogeneic dermal substitute, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.
3717	**Xenograft skin (dermal) for temporary wound closure, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3717	**Xenograft skin (dermal) for temporary wound closure, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.
3718	**Acellular xenograft implant, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3718	**Acellular xenograft implant, each additional must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.
3719	**Incision and drainage, open, of deep abscess not allowed same date of service as related procedures**	**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.	**187**	Date(s) of service.

3719	**Incision and drainage, open, of deep abscess not allowed same date of service as related procedures**	**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.	**259**	Frequency of service.
3719	**Incision and drainage, open, of deep abscess not allowed same date of service as related procedures**	**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.
3720	**Services recouped. Incision and drainage, open, of deep abscess not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
3720	**Services recouped. Incision and drainage, open, of deep abscess not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
3720	**Services recouped. Incision and drainage, open, of deep abscess not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.

3724	**Resection of apical lung tumor not allowed same date of service as related procedures**	**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.	**187**	Date(s) of service.
3724	**Resection of apical lung tumor not allowed same date of service as related procedures**	**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.	**259**	Frequency of service.
3724	**Resection of apical lung tumor not allowed same date of service as related procedures**	**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.
3725	**Services recouped. Resection of apical lung tumor not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
3725	**Services recouped. Resection of apical lung tumor not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
3725	**Services recouped. Resection of apical lung tumor not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.

3728	**Anastomosis, cavopulmonary, second superior vena cava, must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
3728	**Anastomosis, cavopulmonary, second superior vena cava, must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered.
3729	**Anastomosis, cavopulmonary, second superior vena cava not allowed same date of service as related procedures**	**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.	**187**	Date(s) of service.
3729	**Anastomosis, cavopulmonary, second superior vena cava not allowed same date of service as related procedures**	**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.	**259**	Frequency of service.
3729	**Anastomosis, cavopulmonary, second superior vena cava not allowed same date of service as related procedures**	**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

3730	**Services recouped. Anastomosis, cavopulmonary, second superior vena cava not allowed same date of service as related procedures**	**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.	**187**	Date(s) of service.
3730	**Services recouped. Anastomosis, cavopulmonary, second superior vena cava not allowed same date of service as related procedures**	**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.	**259**	Frequency of service.
3730	**Services recouped. Anastomosis, cavopulmonary, second superior vena cava not allowed same date of service as related procedures**	**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
3738	**Repair of pulmonary artery arborization anomalies not allowed same date of service as related procedures**	**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.	**187**	Date(s) of service.

3738	**Repair of pulmonary artery arborization anomalies not allowed same date of service as related procedures**	**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.	**259**	Frequency of service.
3738	**Repair of pulmonary artery arborization anomalies not allowed same date of service as related procedures**	**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
3739	**Services recouped. Repair of pulmonary artery arborization anomalies not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
3739	**Services recouped. Repair of pulmonary artery arborization anomalies not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
3739	**Services recouped. Repair of pulmonary artery arborization anomalies not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered

3740	**Repair of pulmonary artery arborization anomalies not allowed same date of service as related procedures**	**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.	**187**	Date(s) of service.
3740	**Repair of pulmonary artery arborization anomalies not allowed same date of service as related procedures**	**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.	**259**	Frequency of service.
3740	**Repair of pulmonary artery arborization anomalies not allowed same date of service as related procedures**	**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
3741	**Services recouped. Repair of pulmonary artery arborization anomalies not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
3741	**Services recouped. Repair of pulmonary artery arborization anomalies not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.

3741	**Services recouped. Repair of pulmonary artery arborization anomalies not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered
3742	**Contrast injection(s) for radiologic evaluation not allowed same date of service as related procedures**	**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.	**187**	Date(s) of service.
3742	**Contrast injection(s) for radiologic evaluation not allowed same date of service as related procedures**	**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.	**259**	Frequency of service.
3742	**Contrast injection(s) for radiologic evaluation not allowed same date of service as related procedures**	**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
3743	**Services recouped. Contrast injection(s) for radiologic evaluation not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

3743	**Services recouped. Contrast injection(s) for radiologic evaluation not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
3743	**Services recouped. Contrast injection(s) for radiologic evaluation not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered
3744	**Primary percutaneous transluminal mechanical thrombectomy not allowed same date of service as related procedures**	**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.	**187**	Date(s) of service.
3744	**Primary percutaneous transluminal mechanical thrombectomy not allowed same date of service as related procedures**	**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.	**259**	Frequency of service.
3744	**Primary percutaneous transluminal mechanical thrombectomy not allowed same date of service as related procedures**	**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

3745	**Services recouped. Primary percutaneous transluminal mechanical thrombectomy not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
3745	**Services recouped. Primary percutaneous transluminal mechanical thrombectomy not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
3745	**Services recouped. Primary percutaneous transluminal mechanical thrombectomy not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered
3746	**Related codes not allowed same date of 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.	**187**	Date(s) of service.
3746	**Related codes not allowed same date of 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.	**259**	Frequency of service.

3746	**Related codes not allowed same date of 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
3747	**Services recouped. Related codes not allowed same date of service**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
3747	**Services recouped. Related codes not allowed same date of service**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
3747	**Services recouped. Related codes not allowed same date of service**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered
3748	**Primary percutaneous transluminal must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered
3748	**Primary percutaneous transluminal must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered
3749	**Ligation, division, and stripping, short or long saphenous not allowed same date of 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.	**187**	Date(s) of service.

3749	**Ligation, division, and stripping, short or long saphenous not allowed same date of 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.	**259**	Frequency of service.
3749	**Ligation, division, and stripping, short or long saphenous not allowed same date of 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
3750	**Services recouped. Ligation, division, and stripping, short or long saphenous not allowed same date of 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.	**187**	Date(s) of service.
3750	**Services recouped. Ligation, division, and stripping, short or long saphenous not allowed same date of 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.	**259**	Frequency of service.

3750	**Services recouped. Ligation, division, and stripping, short or long saphenous not allowed same date of 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
3751	**Service denied. Immunization administration not allowed same date of service as core clinic visit by same or different provider**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**735**	This service-claim is included in the allowance for another service or claim
3751	**Service denied. Immunization administration not allowed same date of service as core clinic visit by same or different provider**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**735**	This service-claim is included in the allowance for another service or claim
3752	**CAP service recouped. Not allowed same date of service as Adult Care Home services**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service
3753	**Laparascopy, surgical must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered
3753	**Laparascopy, surgical must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered
3754	**Immunization administration has been recouped, service not allowed same day as core clinic visit by same or different provider**	**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.	**735**	This service-claim is included in the allowance for another service or claim

3754	**Immunization administration has been recouped, service not allowed same day as core clinic visit by same or different provider**	**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	**N20**	Service not payable with other service rendered on the same date	**735**	This service-claim is included in the allowance for another service or claim
3755	**Tissue cultured allogeneic skin substitute not allowed same date of 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.	**187**	Date(s) of service.
3755	**Tissue cultured allogeneic skin substitute not allowed same date of 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.	**259**	Frequency of service.
3755	**Tissue cultured allogeneic skin substitute not allowed same date of 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

3756	**Services recouped. Tissue cultured allogeneic skin substitute not allowed same date of 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.	**187**	Date(s) of service.
3756	**Services recouped. Tissue cultured allogeneic skin substitute not allowed same date of 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.	**259**	Frequency of service.
3756	**Services recouped. Tissue cultured allogeneic skin substitute not allowed same date of 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
3757	**Anorectal exam, surgical, requiring anesthesia not allowed same date of service as related procedures**	**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.	**187**	Date(s) of service.

3757	**Anorectal exam, surgical, requiring anesthesia not allowed same date of service as related procedures**	**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.	**259**	Frequency of service.
3757	**Anorectal exam, surgical, requiring anesthesia not allowed same date of service as related procedures**	**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
3758	**Services recouped. Anorectal exam, surgical, requiring anesthesia not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
3758	**Services recouped. Anorectal exam, surgical, requiring anesthesia not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
3758	**Services recouped. Anorectal exam, surgical, requiring anesthesia not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered

3759	**Removal and replacement of internally dwelling ureteral not allowed same date of service as related procedures**	**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.	**187**	Date(s) of service.
3759	**Removal and replacement of internally dwelling ureteral not allowed same date of service as related procedures**	**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.	**259**	Frequency of service.
3759	**Removal and replacement of internally dwelling ureteral not allowed same date of service as related procedures**	**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
3760	**Services recouped. Removal and replacement of internally dwelling ureteral not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
3760	**Services recouped. Removal and replacement of internally dwelling ureteral not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.

3760	**Services recouped. Removal and replacement of internally dwelling ureteral not allowed same date of service as related procedures**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered
3761	**Endometrial sampling must be billed with primary procedure code**	**A1**	Claim-Service denied	**MN19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered
3761	**Endometrial sampling must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered
3762	**Chemotherapy administration must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered
3762	**Chemotherapy administration must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered
3764	**Irrigation of implanted venous access device must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered
3764	**Irrigation of implanted venous access device must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered
3765	**Intravenous infusion, hydration must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered
3765	**Intravenous infusion, hydration must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered
3766	**Intravenous infusion for therapy must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure	**454**	Procedure code for services rendered
3766	**Intravenous infusion for therapy must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered

3767	**Intravenous infusion for therapy must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered
3767	**Intravenous infusion for therapy must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered
3768	**Intravenous infusion for therapy must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered
3768	**Intravenous infusion for therapy must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered
3769	**Therapeutic, prophylactic or diagnostic injection must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered
3769	**Therapeutic, prophylactic or diagnostic injection must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered
3770	**Intravenous infusion therapies not allowed same date of 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.	**187**	Date(s) of service.
3770	**Intravenous infusion therapies not allowed same date of 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.	**259**	Frequency of service.

3770	**Intravenous infusion therapies not allowed same date of 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
3771	**Intravenous infusion therapies not allowed same date of 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.	**187**	Date(s) of service.
3771	**Intravenous infusion therapies not allowed same date of 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.	**259**	Frequency of service.
3771	**Intravenous infusion therapies not allowed same date of 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

3772	**3D rendering with interpretation not allowed same date of service with related 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.	**187**	Date(s) of service.
3772	**3D rendering with interpretation not allowed same date of service with related 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.	**259**	Frequency of service.
3772	**3D rendering with interpretation not allowed same date of service with related 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
3773	**3D rendering with interpretation not allowed same date of service with related 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.	**187**	Date(s) of service.

3773	**3D rendering with interpretation not allowed same date of service with related 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.	**259**	Frequency of service.
3773	**3D rendering with interpretation not allowed same date of service with related 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
3774	**Stereoscopic x-ray guidance not allowed same date of service with related 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.	**187**	Date(s) of service.
3774	**Stereoscopic x-ray guidance not allowed same date of service with related 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.	**259**	Frequency of service.

3774	**Stereoscopic x-ray guidance not allowed same date of service with related 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
3775	**Stereoscopic x-ray guidance not allowed same date of service with related 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.	**187**	Date(s) of service.
3775	**Stereoscopic x-ray guidance not allowed same date of service with related 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.	**259**	Frequency of service.
3775	**Stereoscopic x-ray guidance not allowed same date of service with related 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
3776	**Evaluation of auditory rehabilitation status must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered

3776	**Evaluation of auditory rehabilitation status must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered
3777	**Electrical stimulation must be billed with primary procedure code**	**A1**	Claim-Service denied	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered
3777	**Electrical stimulation must be billed with primary procedure code**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered
3778	**Electrical stimulation not allowed same date of service with related 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.	**187**	Date(s) of service.
3778	**Electrical stimulation not allowed same date of service with related 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.	**259**	Frequency of service.
3778	**Electrical stimulation not allowed same date of service with related 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
3779	**Services recouped. Electrical stimulation not allowed same date of service with related services**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

3779	**Services recouped. Electrical stimulation not allowed same date of service with related services**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
3779	**Services recouped. Electrical stimulation not allowed same date of service with related services**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered
3780	**Electrical stimulation not allowed same date of service with related 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.	**187**	Date(s) of service.
3780	**Electrical stimulation not allowed same date of service with related 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.	**259**	Frequency of service.
3780	**Electrical stimulation not allowed same date of service with related 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
3781	**Services recouped. Electrical stimulation not allowed same date of service with related services**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

3781	**Services recouped. Electrical stimulation not allowed same date of service with related services**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
3781	**Services recouped. Electrical stimulation not allowed same date of service with related services**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered
3790	**Claims payments are being recouped from you due to an HPES system error which caused duplicate claims payments between mid-December 2012 and March 1, 2013**	**18**	Exact Exact duplicate claim-service	**N20**	Service not payable with other service rendered on the same date	**54**	Duplicate of a previously processed claim-line
3791	**Claims payments are being recouped from you due to an HPES system error which caused duplicate claims payments for specific details between mid-December 2012 and March 1, 2013**	**18**	Exact Exact duplicate claim-service	**N20**	Service not payable with other service rendered on the same date	**54**	Duplicate of a previously processed claim-line
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.
3802	**Placement of prosthesis requires endovascular repair.**	**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.	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**454**	Procedure code for services rendered.
3804	**Transposition with carotid artery repair not allowed same day as other transposition.**	**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.	**187**	Date(s) of service.

3804	**Transposition with carotid artery repair not allowed same day as other transposition.**	**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.	**259**	Frequency of service.
3804	**Transposition with carotid artery repair not allowed same day as other transposition.**	**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.
3805	**Initials and- or abbreviations are not acceptable on consent form for first or last name. Abbreviations or illegible signatures must have name printed or typed below signature**	**A1**	Claim-Service denied	**MA75**	Missing-incomplete-invalid patient or authorized representative signature.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3805	**Initials and- or abbreviations are not acceptable on consent form for first or last name. Abbreviations or illegible signatures must have name printed or typed below signature**	**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.
3805	**Initials and- or abbreviations are not acceptable on consent form for first or last name. Abbreviations or illegible signatures must have name printed or typed below signature**	**A1**	Claim-Service denied	**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.

3805	**Initials and- or abbreviations are not acceptable on consent form for first or last name. Abbreviations or illegible signatures must have name printed or typed below signature**	**A1**	Claim-Service denied	**MA75**	Missing-incomplete-invalid patient or authorized representative signature.	**468**	Patient Signature Source
3805	**Initials and- or abbreviations are not acceptable on consent form for first or last name. Abbreviations or illegible signatures must have name printed or typed below signature**	**A1**	Claim-Service denied	**N205**	Information provided was illegible.	**468**	Patient Signature Source
3805	**Initials and- or abbreviations are not acceptable on consent form for first or last name. Abbreviations or illegible signatures must have name printed or typed below signature**	**A1**	Claim-Service denied	**N228**	Incomplete-invalid consent form	**468**	Patient Signature Source
3806	**THE CONSENT FORM IS COMPLETED INCORRECTLY. "DR ON CALL" MUST HAVE NAME OF CLINIC OR FACILITY AND SERVICE (OB-GYN) LISTED**	**A1**	Claim-Service denied	**MA114**	Missing-incomplete-invalid information on where the services were furnished.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3806	**THE CONSENT FORM IS COMPLETED INCORRECTLY. "DR ON CALL" MUST HAVE NAME OF CLINIC OR FACILITY AND SERVICE (OB-GYN) LISTED**	**A1**	Claim-Service denied	**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.

3806	**THE CONSENT FORM IS COMPLETED INCORRECTLY. "DR ON CALL" MUST HAVE NAME OF CLINIC OR FACILITY AND SERVICE (OB-GYN) LISTED**	**A1**	Claim-Service denied	**N292**	Missing-incomplete-invalid service facility name.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
3806	**THE CONSENT FORM IS COMPLETED INCORRECTLY. "DR ON CALL" MUST HAVE NAME OF CLINIC OR FACILITY AND SERVICE (OB-GYN) LISTED**	**A1**	Claim-Service denied	**MA114**	Missing-incomplete-invalid information on where the services were furnished.	**125**	Entitys name.
3806	**THE CONSENT FORM IS COMPLETED INCORRECTLY. "DR ON CALL" MUST HAVE NAME OF CLINIC OR FACILITY AND SERVICE (OB-GYN) LISTED**	**A1**	Claim-Service denied	**N228**	Incomplete-invalid consent form.	**125**	Entitys name.
3806	**THE CONSENT FORM IS COMPLETED INCORRECTLY. "DR ON CALL" MUST HAVE NAME OF CLINIC OR FACILITY AND SERVICE (OB-GYN) LISTED**	**A1**	Claim-Service denied	**N292**	Missing-incomplete-invalid service facility name.	**125**	Entitys name.
3806	**THE CONSENT FORM IS COMPLETED INCORRECTLY. "DR ON CALL" MUST HAVE NAME OF CLINIC OR FACILITY AND SERVICE (OB-GYN) LISTED**	**A1**	Claim-Service denied	**MA114**	Missing-incomplete-invalid information on where the services were furnished.	**306**	Detailed description of service.
3806	**THE CONSENT FORM IS COMPLETED INCORRECTLY. "DR ON CALL" MUST HAVE NAME OF CLINIC OR FACILITY AND SERVICE (OB-GYN) LISTED**	**A1**	Claim-Service denied	**N228**	Incomplete-invalid consent form.	**306**	Detailed description of service.

3806	**THE CONSENT FORM IS COMPLETED INCORRECTLY. "DR ON CALL" MUST HAVE NAME OF CLINIC OR FACILITY AND SERVICE (OB-GYN) LISTED**	**A1**	Claim-Service denied	**N292**	Missing-incomplete-invalid service facility name.	**306**	Detailed description of service.
3807	**CONSENT FOR STERILIZATION IN EMERGENCY SITUATIONS MUST BE SUBMITTED WITH CLAIM AND RECORDS AS AN ADJUSTMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**294**	Supporting documentation.
3807	**CONSENT FOR STERILIZATION IN EMERGENCY SITUATIONS MUST BE SUBMITTED WITH CLAIM AND RECORDS AS AN ADJUSTMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N292**	Missing documentation-orders-notes-summary-report-chart.	**294**	Supporting documentation.
3807	**CONSENT FOR STERILIZATION IN EMERGENCY SITUATIONS MUST BE SUBMITTED WITH CLAIM AND RECORDS AS AN ADJUSTMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**297**	Medical notes-report.
3807	**CONSENT FOR STERILIZATION IN EMERGENCY SITUATIONS MUST BE SUBMITTED WITH CLAIM AND RECORDS AS AN ADJUSTMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N292**	Missing documentation-orders-notes-summary-report-chart.	**297**	Medical notes-report.
3808	**Records indicate second sterilization. Submit adjustment with claim copy, sterilization consent, OP-notes and H&P**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**294**	Supporting documentation.

3808	**Records indicate second sterilization. Submit adjustment with claim copy, sterilization consent, OP-notes and H&P**	**16**	Claim-service lacks information which is needed for adjudication	**N292**	Missing documentation-orders-notes-summary-report-chart.	**294**	Supporting documentation.
3808	**Records indicate second sterilization. Submit adjustment with claim copy, sterilization consent, OP-notes and H&P**	**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.
3808	**Records indicate second sterilization. Submit adjustment with claim copy, sterilization consent, OP-notes and H&P**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**298**	Operative report.
3808	**Records indicate second sterilization. Submit adjustment with claim copy, sterilization consent, OP-notes and H&P**	**16**	Claim-service lacks information which is needed for adjudication	**N292**	Missing documentation-orders-notes-summary-report-chart.	**298**	Operative report.
3808	**Records indicate second sterilization. Submit adjustment with claim copy, sterilization consent, OP-notes and H&P**	**16**	Claim-service lacks information which is needed for adjudication	**N163**	Medical record does not support code billed per the code definition.	**298**	Operative report.
3808	**Records indicate second sterilization. Submit adjustment with claim copy, sterilization consent, OP-notes and H&P**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing consent form.	**316**	Complete medical history
3808	**Records indicate second sterilization. Submit adjustment with claim copy, sterilization consent, OP-notes and H&P**	**16**	Claim-service lacks information which is needed for adjudication	**N292**	Missing documentation-orders-notes-summary-report-chart.	**316**	Complete medical history
3808	**Records indicate second sterilization. Submit adjustment with claim copy, sterilization consent, OP-notes and H&P**	**16**	Claim-service lacks information which is needed for adjudication	**N163**	Medical record does not support code billed per the code definition.	**316**	Complete medical history

3809	**Descending thoracic aorta requires endovascular repair**	**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.	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**454**	Procedure code for services rendered.
3810	**Placement of prosthesis requires endovascular repair.**	**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.	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**454**	Procedure code for services rendered.
3811	**Placement of distal extension prosthesis requires endovascular repair**	**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.	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**454**	Procedure code for services rendered.
3812	**Service denied. Hospice services limited to one unit per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
3812	**Service denied. Hospice services limited to one unit per day.**	**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.
3812	**Service denied. Hospice services limited to one unit per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.

3812	**Service denied. Hospice services limited to one unit per day.**	**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.
3812	**Service denied. Hospice services limited to one unit per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**476**	Missing or invalid units of service.
3812	**Service denied. Hospice services limited to one unit per day.**	**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.	**476**	Missing or invalid units of service.
3813	**Hospice services limited to one unit per day. Units cutback to allowed amount.**	**119**	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.
3813	**Hospice services limited to one unit per day. Units cutback to allowed amount.**	**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.
3813	**Hospice services limited to one unit per day. Units cutback to allowed amount.**	**119**	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.
3813	**Hospice services limited to one unit per day. Units cutback to allowed amount.**	**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.
3813	**Hospice services limited to one unit per day. Units cutback to allowed amount.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**476**	Missing or invalid units of service.
3813	**Hospice services limited to one unit per day. Units cutback to allowed amount.**	**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.	**476**	Missing or invalid units of service.
3814	**Placement of distal prosthesis after endovascular repair not allowed with related repair procedure.**	**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.	**187**	Date(s) of service.

3814	**Placement of distal prosthesis after endovascular repair not allowed with related repair procedure.**	**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.	**259**	Frequency of service.
3814	**Placement of distal prosthesis after endovascular repair not allowed with related repair procedure.**	**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.
3815	**Related repair procedure not allowed with placement of distal prosthesis after endovascular repair.**	**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.	**187**	Date(s) of service.
3815	**Related repair procedure not allowed with placement of distal prosthesis after endovascular repair.**	**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.	**259**	Frequency of service.

3815	**Related repair procedure not allowed with placement of distal prosthesis after endovascular repair.**	**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.
3997	**Only one MCO capitated payment allowed per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
3998	**Add-on code not allowed without primary procedure paid in history for the same date of service, same or different provider**	**A1**	Claim-Service denied	**M51**	Missing-incomplete-invalid, procedure code(s) and-or dates.	**465**	Principal Procedure Code for Service(s) Rendered
3998	**Add-on code not allowed without primary procedure paid in history for the same date of service, same or different provider**	**A1**	Claim-Service denied	**N301**	Missing-incomplete-invalid procedure date(s).	**465**	Principal Procedure Code for Service(s) Rendered
4006	**Dialysis training sessions limited to 25 per lifetime.**	**149**	Lifetime benefit maximum has been reached for this service-benefit category	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
4006	**Dialysis training sessions limited to 25 per lifetime.**	**149**	Lifetime benefit maximum has been reached for this service-benefit category	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
4007	**Completion of dialysis training fee allowed 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.
4008	**General anesthesia limited to 24 units on same DOS.**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**523**	Anesthesia Unit Count
4009	**IV sedation limited to 24 units on same DOS.**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**259**	Frequency of service.
4010	**Medicaid pd maximum allowable for equip.**	**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.

4011	**Tracheostomy care kit limited to 90-month for ages 00-20.**	**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.
4011	**Tracheostomy care kit limited to 90-month for ages 00-20.**	**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.
4012	**Tracheostomy care kit limited to 30-month for ages 21-99.**	**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.
4012	**Tracheostomy care kit limited to**	**119**	Benefit maximum for this time	**N357**	Time frame requirements between this service-procedure-	**259**	Frequency of service.

4021	**Exceeds limitation CAP-MR-DD Comm. Inclusion.**	**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.
4021	**Exceeds limitation CAP-MR-DD Comm. Inclusion.**	**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.
4021	**Exceeds limitation CAP-MR-DD Comm. Inclusion.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
4021	**Exceeds limitation CAP-MR-DD Comm. Inclusion.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**483**	Maximum coverage amount met or exceeded for benefit period.
4022	**CAP home mobility aids limitation has 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.
4022	**CAP home mobility aids limitation has 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.
4022	**CAP home mobility aids limitation has exceeded.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
4022	**CAP home mobility aids limitation has 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	**483**	Maximum coverage amount met or exceeded for benefit period.
4023	**CAP-MR-DD vehicle adapt yearly limitation has been 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.
4023	**CAP-MR-DD vehicle adapt yearly limitation has been 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.
4023	**CAP-MR-DD vehicle adapt yearly limitation has been exceeded.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
4023	**CAP-MR-DD vehicle adapt yearly limitation has been 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	**483**	Maximum coverage amount met or exceeded for benefit period.

4024	**Exceeds CAP-AIDS pers response mon limitations.**	**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.
4024	**Exceeds CAP-AIDS pers response mon limitations.**	**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.
4024	**Exceeds CAP-AIDS pers response mon limitations.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
4024	**Exceeds CAP-AIDS pers response mon limitations.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**483**	Maximum coverage amount met or exceeded for benefit period.
4025	**Related enhanced benefit services not allowed on same day.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4025	**Related enhanced benefit services not allowed on same day.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4025	**Related enhanced benefit services not allowed on same day.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4025	**Related enhanced benefit services not allowed on same day.**	**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.
4025	**Related enhanced benefit services not allowed on same day.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
4025	**Related enhanced benefit services not allowed on same day.**	**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.
4027	**Exceeds once-month limitations.**	**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.

4027	**Exceeds once-month limitations.**	**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.
4028	**Exceeds once-month limitations.**	**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.
					between this service-procedure-		

4031	**Radiation treatment delivery limited to 3- day.**	**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.
4031	**Radiation treatment delivery limited to 3- 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	**612**	Per Day Limit Amount
					between this service-procedure-		

4037	**Vitrocert limited to two units in 240 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.
4037	**Vitrocert limited to two units in 240 days.**	**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.
4037	**Vitrocert limited to two units in 240 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.
4038	**Purchase-rental-repair of augmentative devices allowed once 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.
4038	**Purchase-rental-repair of augmentative devices allowed once 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
4042	**Radiation treatment management for cranial lesions not allowed same day as stereotactic radiosurgery services.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4042	**Radiation treatment management for cranial lesions not allowed same day as stereotactic radiosurgery services.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4042	**Radiation treatment management for cranial lesions not allowed same day as stereotactic radiosurgery services.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4042	**Radiation treatment management for cranial lesions not allowed same day as stereotactic radiosurgery services.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.

4042	**Radiation treatment management for cranial lesions not allowed same day as stereotactic radiosurgery services.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
4042	**Radiation treatment management for cranial lesions not allowed same day as stereotactic radiosurgery services.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
4043	**Service recouped. Stereotactic radiosurgery services not allowed same day as radiation treatment management for cranial lesions.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4043	**Service recouped. Stereotactic radiosurgery services not allowed same day as radiation treatment management for cranial lesions.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4043	**Service recouped. Stereotactic radiosurgery services not allowed same day as radiation treatment management for cranial lesions.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4043	**Service recouped. Stereotactic radiosurgery services not allowed same day as radiation treatment management for cranial lesions.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
4043	**Service recouped. Stereotactic radiosurgery services not allowed same day as radiation treatment management for cranial lesions.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

4043	**Service recouped. Stereotactic radiosurgery services not allowed same day as radiation treatment management for cranial lesions.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
4044	**Radiation treatment management for extracranial lesions not same as stereotactic radiosurgery services**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4044	**Radiation treatment management for extracranial lesions not same as stereotactic radiosurgery services**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4044	**Radiation treatment management for extracranial lesions not same as stereotactic radiosurgery services**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4044	**Radiation treatment management for extracranial lesions not same as stereotactic radiosurgery services**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
4044	**Radiation treatment management for extracranial lesions not same as stereotactic radiosurgery services**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
4044	**Radiation treatment management for extracranial lesions not same as stereotactic radiosurgery services**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
4045	**Service recouped. Stereotactic radiosurgery services not allowed same day as radiation treatment for extracranial lesions.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

4045	**Service recouped. Stereotactic radiosurgery services not allowed same day as radiation treatment for extracranial lesions.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4045	**Service recouped. Stereotactic radiosurgery services not allowed same day as radiation**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
					between this service-procedure-		

4049	**Intranasal and H1N1 vaccine not allowed on the same date of service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4049	**Intranasal and H1N1 vaccine not**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date	**454**	Procedure code for services rendered.
					between this service-procedure-		

4062	**Related procedure not allowed the same date of service as sleep study already paid for this date**	**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	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Dates of service
4062	**Related procedure not allowed**	**A1**	Claim-Service denied. At least	**N357**	Time frame requirements	**187**	Dates of service
					between this service-procedure-		

4091	**Related vaccines are not allowed on the same date of service**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
4091	**Related vaccines are not allowed on the same date of service**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**259**	Frequency of service
4095	**Only one sleep study procedure per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
4095	**Only one sleep study procedure per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
4096	**One multiple extremity electromyography procedure per DOS.**	**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.
4096	**One multiple extremity electromyography procedure per DOS.**	**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
4097	**One home visit allowed per DOS.**	**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.
4097	**One home visit allowed per DOS.**	**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
4100	**PROVIDERS BILLING FOR DATES OF SERVICE AFTER JUNE 1, 2004, MUST BILL ONLY THE APPLICABLE NATIONAL CODES AND-OR CORRESPONDING REVENUE CODES.**	**125**	Submission-billing error(s)	**M50**	Missing-incomplete-invalid revenue code(s).	**454**	Procedure code for services rendered.

4100	**PROVIDERS BILLING FOR DATES OF SERVICE AFTER JUNE 1, 2004, MUST BILL ONLY THE APPLICABLE NATIONAL CODES AND-OR CORRESPONDING REVENUE CODES.**	**125**	Submission-billing error(s)	**M51**	Missing-incomplete-invalid, procedure code(s) and-or dates.	**454**	Procedure code for services rendered.
4100	**PROVIDERS BILLING FOR DATES OF SERVICE AFTER JUNE 1, 2004, MUST BILL ONLY THE APPLICABLE NATIONAL CODES AND-OR CORRESPONDING REVENUE CODES.**	**125**	Submission-billing error(s)	**M50**	Missing-incomplete-invalid revenue code(s).	**455**	Revenue code for services rendered.
4100	**PROVIDERS BILLING FOR DATES OF SERVICE AFTER JUNE 1, 2004, MUST BILL ONLY THE APPLICABLE NATIONAL CODES AND-OR CORRESPONDING REVENUE CODES.**	**125**	Submission-billing error(s)	**M51**	Missing-incomplete-invalid, procedure code(s) and-or dates.	**455**	Revenue code for services rendered.
4101	**The number of ACH facility beds is not listed on the provider file for provider type.**	**125**	Submission-billing error(s)	**N65**	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service-provider.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
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-adjusdication 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-adjusdication 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-adjusdication 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-adjusdication must reference the newly assigned payer claim control number for this previously adjusted claim. Correct the payer claim control number and resubmit.
4104	**THE NUMBER OF ACH BEDS ARE NOT LISTED ON THE PROVIDER FILE FOR PROVIDER.**	**125**	Submission-billing error(s)	**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.
4104	**THE NUMBER OF ACH BEDS ARE NOT LISTED ON THE PROVIDER FILE FOR PROVIDER.**	**125**	Submission-billing error(s)	**N65**	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service-provider.	**455**	Revenue code for services rendered
4116	**Suspect dup, same procedure code.**	**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.
4118	**Suspect dup, exact service date.**	**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.
4120	**Units cutback. Maximum number of units exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
4120	**Units cutback. Maximum number of units exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4120	**Units cutback. Maximum number of units exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
4120	**Units cutback. Maximum number of units exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.

4124	**Rental cost exceeds purchase price for 1 year, ages 021 - 115**	**108**	Rent-purchase guidelines were not met. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M7**	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.	**186**	Purchase and rental price of durable medical equipment.
4124	**Rental cost exceeds purchase price for 1 year, ages 021 - 115**	**108**	Rent-purchase guidelines were not met. 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	**186**	Purchase and rental price of durable medical equipment.
4152	**Delivery only or related abdominal surgery not allowed same day as delivery with postpartum care by same attending**	**125**	Submission-billing error(s)	**N20**	Service not payable with other services rendered on the same date.	**454**	Procedure code for services rendered.
4153	**Delivery with postpartum care performed this day by same attending. Delivery only or related abdominal surgery recouped**	**125**	Submission-billing error(s)	**N20**	Service not payable with other services rendered on the same date.	**454**	Procedure code for services rendered.
4196	**Suspect dup, same header DOS ,same billing provider, amt**	**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.
4200	**Allow one topical flouride varnish application every 60 days**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**259**	Frequency of service
4201	**Incision procedure is a component of surgical procedure already paid for this date of service. No payment allowed for current procedure**	**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.	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**187**	Date(s) of service.

4201	**Incision procedure is a component of surgical procedure already paid for this date of service. No payment allowed for current procedure**	**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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4201	**Incision procedure is a component of surgical procedure already paid for this date of service. No payment allowed for current procedure**	**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.	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4201	**Incision procedure is a component of surgical procedure already paid for this date of service. No payment allowed for current procedure**	**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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4202	**Surgical procedure does not allow separate incision component on same day. Component recouped**	**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.	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**187**	Date(s) of service.

4202	**Surgical procedure does not allow separate incision component on same day. Component recouped**	**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.	**N20**	Service not payable with other service rendered on	**187**	Date(s) of service.
4202	**Surgical procedure does not allow separate incision component on same day. Component recouped**	**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.	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4202	**Surgical procedure does not allow separate incision component on same day. Component recouped**	**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.	**N20**	Service not payable with other service rendered on	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4212	**Claim denied. DEA number not allowed, resubmit claim with prescriber NPI number**	**A1**	Claim-Service denied	**N433**	Resubmit this claim using only your National Provider Identifier (NPI)	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information
4212	**Claim denied. DEA number not allowed, resubmit claim with prescriber NPI number**		Claim-Service denied	**N433**	Resubmit this claim using only your National Provider Identifier (NPI)	**562**	Entitys National Provider Identifier (NPI). Note- This code requires use of an Entity Code

4213	**Exceeds 60 procedures per day limitation**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4213	**Exceeds 60 procedures per day limitation**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not	**454**	Procedure code for services rendered.
					between this service-procedure-		

4215	**Prescriber NPI on claim is missing or invalid. Resubmit with correct NPI number**	**A1**	Claim-Service denied	**N433**	Resubmit this claim using only your National Provider Identifier (NPI)	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information
4215	**Prescriber NPI on claim is missing or invalid. Resubmit with correct NPI number**	**A1**	Claim-Service denied	**N433**	Resubmit this claim using only your National Provider Identifier (NPI)	**562**	Entitys National Provider Identifier (NPI). Note- This code requires use of an Entity Code
4219	**Thromboendarterectomy and Harvest of upper extremity vein are not allowed on the same date of service**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4219	**Thromboendarterectomy and Harvest of upper extremity vein are not allowed on the same date of service**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4219	**Thromboendarterectomy and Harvest of upper extremity vein are not allowed on the same date of service**	**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
4219	**Thromboendarterectomy and Harvest of upper extremity vein are not allowed on the same date of service**	**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
4221	**Related bypass procedures not allowed on the same date of service**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

4221	**Related bypass procedures not allowed on the same date of service**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4221	**Related bypass procedures not allowed on the same date of service**	**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
4221	**Related bypass procedures not allowed on the same date of service**	**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
4229	**Claim denied. Ultrasound of transplanted kidney not allowed same day as visceral and penile vascular studies**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4229	**Claim denied. Ultrasound of transplanted kidney not allowed same day as visceral and penile vascular studies**	**A1**	Claim-Service denied	**N20**	N20 - Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4229	**Claim denied. Ultrasound of transplanted kidney not allowed same day as visceral and penile vascular studies**	**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
4229	**Claim denied. Ultrasound of transplanted kidney not allowed same day as visceral and penile vascular studies**	**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
4230	**Claim recouped. Ultrasound of transplanted kidney not allowed same day as visceral and penile vascular studies**	**169**	Alternate benefit has been provided	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4230	**Claim recouped. Ultrasound of transplanted kidney not allowed same day as visceral and penile vascular studies**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.

4230	**Claim recouped. Ultrasound of transplanted kidney not allowed same day as visceral and penile vascular studies**	**169**	Alternate benefit has been provided	**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
4230	**Claim recouped. Ultrasound of transplanted kidney not allowed same day as visceral and penile vascular studies**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4231	**Claim denied. Ultrasonic guidance, intraoperative not allowed same day as laparoscopy**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4231	**Claim denied. Ultrasonic guidance, intraoperative not allowed same day as laparoscopy**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4231	**Claim denied. Ultrasonic guidance, intraoperative not allowed same day as laparoscopy**	**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
4231	**Claim denied. Ultrasonic guidance, intraoperative not allowed same day as laparoscopy**	**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
4232	**Claim recouped. Ultrasonic Guidance, intraoperative not allowed same day as laparoscopy**	**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.	**187**	Date(s) of service.

4232	**Claim recouped. Ultrasonic Guidance, intraoperative not allowed same day as laparoscopy**	**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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4232	**Claim recouped. Ultrasonic Guidance, intraoperative not allowed same day as laparoscopy**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4232	**Claim recouped. Ultrasonic Guidance, intraoperative not allowed same day as laparoscopy**	**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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4233	**Related fluoroscopic guidance procedures not allowed on the same date of service**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4233	**Related fluoroscopic guidance procedures not allowed on the same date of service**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4233	**Related fluoroscopic guidance procedures not allowed on the same date of service**	**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

4233	**Related fluoroscopic guidance procedures not allowed on the same date of service**	**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
4234	**Claim recouped. Related fluoroscopic guidance procedures not allowed on the same date of service**	**169**	Alternate benefit has been provided	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4234	**Claim recouped. Related fluoroscopic guidance procedures not allowed on the same date of service**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4234	**Claim recouped. Related fluoroscopic guidance procedures not allowed on the same date of service**	**169**	Alternate benefit has been provided	**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
4234	**Claim recouped. Related fluoroscopic guidance procedures not allowed on the same date of service**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4235	**Claim denied. Fluoroscopic guidance for needle placement not allowed same day as radiological examination**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date (s) of service.
4235	**Claim denied. Fluoroscopic guidance for needle placement not allowed same day as radiological examination**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date (s) of service.
4235	**Claim denied. Fluoroscopic guidance for needle placement not allowed same day as radiological examination**	**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
4235	**Claim denied. Fluoroscopic guidance for needle placement not allowed same day as radiological examination**	**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

4236	**Claim recouped. Fluoroscopic guidance for needle placement not allowed same day as radiological examination**	**169**	Alternate benefit has been provided	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4236	**Claim recouped. Fluoroscopic guidance for needle placement not allowed same day as radiological examination**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4236	**Claim recouped. Fluoroscopic guidance for needle placement not allowed same day as radiological examination**	**169**	Alternate benefit has been provided	**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
4236	**Claim recouped. Fluoroscopic guidance for needle placement not allowed same day as radiological examination**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4237	**Claim denied. Fluoroscopic guidance not allowed same day as surgical or radiological procedures**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4237	**Claim denied. Fluoroscopic guidance not allowed same day as surgical or radiological procedures**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4237	**Claim denied. Fluoroscopic guidance not allowed same day as surgical or radiological procedures**	**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
4237	**Claim denied. Fluoroscopic guidance not allowed same day as surgical or radiological procedures**	**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

4238	**Claim recouped. Fluoroscopic guidance not allowed same day as surgical or radiological procedures**	**169**	Alternate benefit has been provided	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4238	**Claim recouped. Fluoroscopic guidance not allowed same day as surgical or radiological procedures**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4238	**Claim recouped. Fluoroscopic guidance not allowed same day as surgical or radiological procedures**	**169**	Alternate benefit has been provided	**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
4238	**Claim recouped. Fluoroscopic guidance not allowed same day as surgical or radiological procedures**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4239	**Claim denied. Fluoroscopic guidance not allowed same day as myelography procedures**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4239	**Claim denied. Fluoroscopic guidance not allowed same day as myelography procedures**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4239	**Claim denied. Fluoroscopic guidance not allowed same day as myelography procedures**	**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
4239	**Claim denied. Fluoroscopic guidance not allowed same day as myelography procedures**	**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
4241	**Claim denied. Computerized tomography guidance not allowed same day as related procedure**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

4241	**Claim denied. Computerized tomography guidance not allowed same day as related procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4241	**Claim denied. Computerized tomography guidance not allowed same day as related procedure**	**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
4241	**Claim denied. Computerized tomography guidance not allowed same day as related procedure**	**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
4242	**Claim recouped. Computerized tomography guidance previously paid**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4243	**Claim denied. laparoscopy-hysteroscopy not allowed same day as related surgery**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4243	**Claim denied. laparoscopy-hysteroscopy not allowed same day as related surgery**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4243	**Claim denied. laparoscopy-hysteroscopy not allowed same day as related surgery**	**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
4243	**Claim denied. laparoscopy-hysteroscopy not allowed same day as related surgery**	**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

4244	**Claim recouped. Laparoscopy-hysteroscopy not allowed same day as related surgery**	**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.	**187**	Date(s) of service.
4244	**Claim recouped. Laparoscopy-hysteroscopy not allowed same day as related surgery**	**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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4244	**Claim recouped. Laparoscopy-hysteroscopy not allowed same day as related surgery**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4244	**Claim recouped. Laparoscopy-hysteroscopy not allowed same day as related surgery**	**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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4245	**Claim denied. Abdominal laparoscopy not allowed same day as laparoscopy-hysteroscopy**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

4245	**Claim denied. Abdominal laparoscopy not allowed same day as laparoscopy-hysteroscopy**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4245	**Claim denied. Abdominal laparoscopy not allowed same day as laparoscopy-hysteroscopy**	**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
4245	**Claim denied. Abdominal laparoscopy not allowed same day as laparoscopy-hysteroscopy**	**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
4246	**Claim recouped. Abdominal laparoscopy not allowed same day as laparoscopy-hysteroscopy**	**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.	**187**	Date(s) of service.
4246	**Claim recouped. Abdominal laparoscopy not allowed same day as laparoscopy-hysteroscopy**	**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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4246	**Claim recouped. Abdominal laparoscopy not allowed same day as laparoscopy-hysteroscopy**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered

4246	**Claim recouped. Abdominal laparoscopy not allowed same day as laparoscopy-hysteroscopy**	**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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4247	**Claim denied. Surgical laparoscopy not allowed same day as laparoscopy with radical hysterectomy**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4247	**Claim denied. Surgical laparoscopy not allowed same day as laparoscopy with radical hysterectomy**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4247	**Claim denied. Surgical laparoscopy not allowed same day as laparoscopy with radical hysterectomy**	**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
4247	**Claim denied. Surgical laparoscopy not allowed same day as laparoscopy with radical hysterectomy**	**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
4248	**Claim recouped. Surgical laparoscopy not allowed same day as laparoscopy with radical hysterectomy**	**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.	**187**	Date(s) of service.

4248	**Claim recouped. Surgical laparoscopy not allowed same day as laparoscopy with radical hysterectomy**	**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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4248	**Claim recouped. Surgical laparoscopy not allowed same day as laparoscopy with radical hysterectomy**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4248	**Claim recouped. Surgical laparoscopy not allowed same day as laparoscopy with radical hysterectomy**	**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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4249	**Claim denied. Related surgical procedures not allowed same day as resection (tumor debulking)**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4249	**Claim denied. Related surgical procedures not allowed same day as resection (tumor debulking)**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4249	**Claim denied. Related surgical procedures not allowed same day as resection (tumor debulking)**	**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

4249	**Claim denied. Related surgical procedures not allowed same day as resection (tumor debulking)**	**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
4250	**Claim recouped. Related surgical procedures not allowed same day as resection (tumor debulking)**	**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.	**187**	Date(s) of service.
4250	**Claim recouped. Related surgical procedures not allowed same day as resection (tumor debulking)**	**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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4250	**Claim recouped. Related surgical procedures not allowed same day as resection (tumor debulking)**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4250	**Claim recouped. Related surgical procedures not allowed same day as resection (tumor debulking)**	**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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered

4258	**Claim denied. Physician supervision of patients under care of home health not allowed within 30 days of pediatric home apnea monitoring event**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**454**	Procedure code for services rendered
4259	**Claim recouped. Physician**	**169**	Alternate benefit has been	**N357**	Time frame requirements between this service-procedure-	**454**	Procedure code for services

4263	**Procedure-modifier limited to 2 units per day. If additional units were provided rebill as adjustment with medical records**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount
4264	**If multiple units were provided rebill with appropriate modifiers**	**A1**	Claim-Service denied	**M53**	Missing-incomplete-invalid days or units of service	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4265	**Exceeds 3 units per day limitation**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service. period.
4265	**Exceeds 3 units per day limitation**	**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.
4265	**Exceeds 3 units per day limitation**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**483**	Maximum coverage amount met or exceeded for benefit
4265	**Exceeds 3 units per day limitation**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**483**	Maximum coverage amount met or exceeded for benefit
4265	**Exceeds 3 units per day limitation**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
4265	**Exceeds 3 units per day limitation**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount
4267	**Exceeds 4 units per 31 day limitation**	**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.
4267	**Exceeds 4 units per 31 day 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.
4267	**Exceeds 4 units per 31 day limitation**	**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

4267	**Exceeds 4 units per 31 day 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	**483**	Maximum coverage amount met or exceeded for benefit period
4269	**Orthotic or Prosthetic Equipment allowed once every 18 months for ages 000-005. Units Cutback to allowed amount.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N129**	Not eligible due to the patients age.	**258**	Days-units for procedure-revenue code.
4269	**Orthotic or Prosthetic Equipment allowed once every 18 months for ages 000-005. Units Cutback to allowed amount.**	**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.
4269	**Orthotic or Prosthetic Equipment allowed once every 18 months for ages 000-005. Units Cutback to allowed amount.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N129**	Not eligible due to the patients age.	**259**	Frequency of service.
4269	**Orthotic or Prosthetic Equipment allowed once every 18 months for ages 000-005. Units Cutback to allowed amount.**	**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.
4270	**Related cardiovascular surgeries not allowed same DOS**	**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.	**187**	Date(s) of service.
4270	**Related cardiovascular surgeries not allowed same DOS**	**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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.

4270	**Related cardiovascular surgeries not allowed same DOS**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4270	**Related cardiovascular surgeries not allowed same DOS**	**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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4271	**Units cutback. Exceeds maximum units allowed per day**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4271	**Units cutback. Exceeds maximum units allowed per day**	**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.
4271	**Units cutback. Exceeds maximum units allowed per day**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4271	**Units cutback. Exceeds maximum units allowed per day**	**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.
4271	**Units cutback. Exceeds maximum units allowed per day**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
4271	**Units cutback. Exceeds maximum units allowed per day**	**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	**612**	Per Day Limit Amount
4272	**Inhalation treatment, first hour once per day**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**187**	Date(s) of service.

4272	**Inhalation treatment, first hour once per day**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
4272	**Inhalation treatment, first hour once per day**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**612**	Per Day Limit Amount
4273	**Related pulmonary procedures not allowed same date of service**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4273	**Related pulmonary procedures not allowed same date of service**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4273	**Related pulmonary procedures not allowed same date of service**	**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
4273	**Related pulmonary procedures not allowed same date of service**	**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
4274	**Related pulmonary procedures not allowed same date of service**	**169**	Alternate benefit has been provided	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4274	**Related pulmonary procedures not allowed same date of service**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4274	**Related pulmonary procedures not allowed same date of service**	**169**	Alternate benefit has been provided	**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
4274	**Related pulmonary procedures not allowed same date of service**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered

4275	**Catherization not allowed same day as comprehensive surgical procedure**	**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.	**187**	Date(s) of service.
4275	**Catherization not allowed same day as comprehensive surgical procedure**	**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.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4275	**Catherization not allowed same day as comprehensive surgical procedure**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4275	**Catherization not allowed same day as comprehensive surgical procedure**	**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.	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered

4276	**Comprehensive surgical procedure not allowed same day as related catherization. Catherization recouped**	**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.	**187**	Date(s) of service.
4276	**Comprehensive surgical procedure not allowed same day as related catherization. Catherization recouped**	**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.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4276	**Comprehensive surgical procedure not allowed same day as related catherization. Catherization recouped**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4276	**Comprehensive surgical procedure not allowed same day as related catherization. Catherization recouped**	**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.	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4277	**Delayed creation of exit site not allowed same day as insertion of intraperitoneal cannula or catheter**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

4277	**Delayed creation of exit site not allowed same day as insertion of intraperitoneal cannula or catheter**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4277	**Delayed creation of exit site not allowed same day as insertion of intraperitoneal cannula or catheter**	**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
4277	**Delayed creation of exit site not allowed same day as insertion of intraperitoneal cannula or catheter**	**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
4278	**Insertion procedure not allowed same day as related procedure. Delayed creation of exit site procedure recouped**	**169**	Alternate benefit has been provided	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4278	**Insertion procedure not allowed same day as related procedure. Delayed creation of exit site procedure recouped**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4278	**Insertion procedure not allowed same day as related procedure. Delayed creation of exit site procedure recouped**	**169**	Alternate benefit has been provided	**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
4278	**Insertion procedure not allowed same day as related procedure. Delayed creation of exit site procedure recouped**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered

4279	**Related treatment procedure not allowed same day as stereotactic radiation treatments**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4279	**Related treatment procedure not allowed same day as stereotactic radiation treatments**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4279	**Related treatment procedure not allowed same day as stereotactic radiation treatments**	**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
4279	**Related treatment procedure not allowed same day as stereotactic radiation treatments**	**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
4280	**Stereotactic radiation treatment not allowed same day as related treatment procedure**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4280	**Stereotactic radiation treatment not allowed same day as related treatment procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4280	**Stereotactic radiation treatment not allowed same day as related treatment procedure**	**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
4280	**Stereotactic radiation treatment not allowed same day as related treatment procedure**	**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

4281	**Radiation management not allowed same date of service as radiation therapy**	**169**	Alternate benefit has been provided	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4281	**Radiation management not allowed same date of service as radiation therapy**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4281	**Radiation management not allowed same date of service as radiation therapy**	**169**	Alternate benefit has been provided	**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
4281	**Radiation management not allowed same date of service as radiation therapy**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4282	**Radiation therapy not allowed same date of service as radiation treatment**	**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.	**187**	Date(s) of service.
4282	**Radiation therapy not allowed same date of service as radiation treatment**	**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.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.

4282	**Radiation therapy not allowed same date of service as radiation treatment**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4282	**Radiation therapy not allowed same date of service as radiation treatment**	**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.	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4285	**Cardiovascular graft procedure not allowed same day as related cardiovascular surgery procedure**	**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.	**187**	Date(s) of service.
4285	**Cardiovascular graft procedure not allowed same day as related cardiovascular surgery procedure**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.

4285	**Cardiovascular graft procedure not allowed same day as related cardiovascular surgery procedure**	**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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4285	**Cardiovascular graft procedure not allowed same day as related cardiovascular surgery procedure**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4285	**Cardiovascular graft procedure not allowed same day as related cardiovascular surgery procedure**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4285	**Cardiovascular graft procedure not allowed same day as related cardiovascular surgery procedure**	**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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered

4286	**Cardiovascular surgery procedure not allowed same day as related cardiovascular graft. Graft procedure recouped**	**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.	**187**	Date(s) of service.
4286	**Cardiovascular surgery procedure not allowed same day as related cardiovascular graft. Graft procedure recouped**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4286	**Cardiovascular surgery procedure not allowed same day as related cardiovascular graft. Graft procedure recouped**	**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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4286	**Cardiovascular surgery procedure not allowed same day as related cardiovascular graft. Graft procedure recouped**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered

4286	**Cardiovascular surgery procedure not allowed same day as related cardiovascular graft. Graft procedure recouped**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4286	**Cardiovascular surgery procedure not allowed same day as related cardiovascular graft. Graft procedure recouped**	**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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4288	**Insertion procedure not allowed same date of service as repair procedure**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4288	**Insertion procedure not allowed same date of service as repair procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4288	**Insertion procedure not allowed same date of service as repair procedure**	**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
4288	**Insertion procedure not allowed same date of service as repair procedure**	**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
4289	**Repair procedure not allowed same date of service as related insertion procedure. Insertion procedure recouped**	**167**	Alternate benefit has been provided	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

4289	**Repair procedure not allowed same date of service as related insertion procedure. Insertion procedure recouped**	**167**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4289	**Repair procedure not allowed same date of service as related insertion procedure. Insertion procedure recouped**	**167**	Alternate benefit has been provided	**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
4289	**Repair procedure not allowed same date of service as related insertion procedure. Insertion procedure recouped**	**167**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4290	**Component of surgical incision-closure procedure not allowed on same date of service as a related closure procedure**	**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.	**187**	Date(s) of service.
4290	**Component of surgical incision-closure procedure not allowed on same date of service as a related closure procedure**	**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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4290	**Component of surgical incision-closure procedure not allowed on same date of service as a related closure procedure**	**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.	**259**	Frequency of service.

4290	**Component of surgical incision-closure procedure not allowed on same date of service as a related closure procedure**	**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.	**N20**	Service not payable with other service rendered on the same date	**259**	Frequency of service.
4290	**Component of surgical incision-closure procedure not allowed on same date of service as a related closure procedure**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4290	**Component of surgical incision-closure procedure not allowed on same date of service as a related closure procedure**	**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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4291	**Related closure procedure not allowed same day as component incision-closure procedure. Component incision-closure procedure recouped**	**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.	**187**	Date(s) of service.

4291	**Related closure procedure not allowed same day as component incision-closure procedure. Component incision-closure procedure recouped**	**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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4291	**Related closure procedure not allowed same day as component incision-closure procedure. Component incision-closure procedure recouped**	**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.	**259**	Frequency of service.
4291	**Related closure procedure not allowed same day as component incision-closure procedure. Component incision-closure procedure recouped**	**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.	**N20**	Service not payable with other service rendered on the same date	**259**	Frequency of service.
4291	**Related closure procedure not allowed same day as component incision-closure procedure. Component incision-closure procedure recouped**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered

4291	**Related closure procedure not allowed same day as component incision-closure procedure. Component incision-closure procedure recouped**	**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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4292	**Surgical procedure not allowed same day as separate scopy procedure**	**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.	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**187**	Date(s) of service.
4292	**Surgical procedure not allowed same day as separate scopy procedure**	**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.	**187**	Date(s) of service.
4292	**Surgical procedure not allowed same day as separate scopy procedure**	**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.	**N20**	Service not payable with other service rendered on	**187**	Date(s) of service.

4292	**Surgical procedure not allowed same day as separate scopy procedure**	**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.	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4292	**Surgical procedure not allowed same day as separate scopy procedure**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4292	**Surgical procedure not allowed same day as separate scopy procedure**	**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.	**N20**	Service not payable with other service rendered on	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4293	**Separate scopy procedure not allowed same day as surgical procedure**	**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.	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**187**	Date(s) of service.

4293	**Separate scopy procedure not allowed same day as surgical procedure**	**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.	**187**	Date(s) of service.
4293	**Separate scopy procedure not allowed same day as surgical procedure**	**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.	**N20**	Service not payable with other service rendered on	**187**	Date(s) of service.
4293	**Separate scopy procedure not allowed same day as surgical procedure**	**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.	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4293	**Separate scopy procedure not allowed same day as surgical procedure**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered

4293	**Separate scopy procedure not allowed same day as surgical procedure**	**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.	**N20**	Service not payable with other service rendered on	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4294	**Repair procedures not allowed same day as excision of skin**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4294	**Repair procedures not allowed same day as excision of skin**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4294	**Repair procedures not allowed same day as excision of skin**	**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.
4294	**Repair procedures not allowed same day as excision of skin**	**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.
4295	**Excision of skin not allowed same day as repair procedures**	**169**	Payment adjusted because an alternate benefit has been provided	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4295	**Excision of skin not allowed same day as repair procedures**	**169**	Payment adjusted because an alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4295	**Excision of skin not allowed same day as repair procedures**	**169**	Payment adjusted because an alternate benefit has been provided	**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.
4295	**Excision of skin not allowed same day as repair procedures**	**169**	Payment adjusted because an alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered.

4296	**Corneal topography not allowed same day as keratoplasty**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4296	**Corneal topography not allowed same day as keratoplasty**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4296	**Corneal topography not allowed same day as keratoplasty**	**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.
4296	**Corneal topography not allowed same day as keratoplasty**	**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.
4297	**Corneal topography recouped. Service not allowed same day as keratoplasty**	**169**	Alternate benefit has been provided	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4297	**Corneal topography recouped. Service not allowed same day as keratoplasty**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4297	**Corneal topography recouped. Service not allowed same day as keratoplasty**	**169**	Alternate benefit has been provided	**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.
4297	**Corneal topography recouped. Service not allowed same day as keratoplasty**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
4300	**DME IOU limited per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

4300	**DME IOU limited per calendar month**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4301	**Denied - DME IOU limited per 6 calendar months.**	**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.
4301	**Denied - DME IOU limited per 6 calendar months.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4302	**DME IOU limited ounces per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
4302	**DME IOU limited ounces per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4303	**DME IOU limited ounces per 6 calendar months.**	**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.
4303	**DME IOU limited ounces per 6 calendar months.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4304	**DME IOU limited tablets per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
4304	**DME IOU limited tablets per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4305	**DME IOU limitation of 150 per 6 calendar months exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4305	**DME IOU limitation of 150 per 6 calendar months exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.

4306	**DME IOU limitation of 2 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4306	**DME IOU limitation of 2 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4307	**DME IOU limitation of 3 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4307	**DME IOU limitation of 3 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4308	**DME IOU limitation of 4 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4308	**DME IOU limitation of 4 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4309	**DME IOU limitation of 10 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4309	**DME IOU limitation of 10 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4310	**DME IOU limitation of 15 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4310	**DME IOU limitation of 15 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4311	**DME IOU limitation of 20 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4311	**DME IOU limitation of 20 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4312	**DME IOU limitation of 31 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4312	**DME IOU limitation of 31 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.

4313	**DME IOU limitation of 35 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4313	**DME IOU limitation of 35 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4314	**DME IOU limitation of 60 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4314	**DME IOU limitation of 60 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4315	**DME IOU limitation of 80 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4315	**DME IOU limitation of 80 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4316	**DME IOU limitation of 192 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4316	**DME IOU limitation of 192 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4317	**DME IOU limitation of 200 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4317	**DME IOU limitation of 200 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4318	**DME IOU limitation of 1 box of 50 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4318	**DME IOU limitation of 1 box of 50 per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4319	**DME IOU limitation of 2 per 6 calendar months exceeded**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4319	**DME IOU limitation of 2 per 6 calendar months exceeded**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.

4320	**DME IOU limitation of 4 ounces per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4320	**DME IOU limitation of 4 ounces per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4321	**DME IOU limitation of 16 ounces per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4321	**DME IOU limitation of 16 ounces per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4322	**DME IOU limitation of 3 per 6 calendar months exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4322	**DME IOU limitation of 3 per 6 calendar months exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4323	**DME IOU limitation of one per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4323	**DME IOU limitation of one per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4324	**DME IOU limitation of 2 ounces per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4324	**DME IOU limitation of 2 ounces per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4325	**DME IOU limitation of 1 (16oz) per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4325	**DME IOU limitation of 1 (16oz) per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4326	**DME IOU limitation of 100 tablets per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4326	**DME IOU limitation of 100 tablets per calendar month exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.

4327	**DME IOU limitation of 16 ounces per 6 per calendar months exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4327	**DME IOU limitation of 16 ounces per 6 per calendar months**	**119**	Benefit maximum for this time period or occurrence has been	**N362**	The number of Days or Units of Service exceeds our	**259**	Frequency of service.
					between this service-procedure-		

4368	**Service denied. Exceeds the limitation of units allowed per 28 days.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
4368	**Service denied. Exceeds the limitation of units allowed per 28**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-	**259**	Frequency of service.
					between this service-procedure-		

4371	**Orthotic or Prosthetic equipment allowed six per year for ages 000-002. Units cutback to allowed amount.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N129**	Not eligible due to the patients age.	**259**	Frequency of service.
					between this service-procedure-		

4373	**Drug units cutback to the allowable 210 units per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M53**	Missing-incomplete-invalid days or units of service.	**258**	Days-units for procedure-revenue code.
4373	**Drug units cutback to the allowable 210 units per calendar**	**119**	Benefit maximum for this time period or occurrence has been	**N357**	Time frame requirements between this service-procedure-	**258**	Days-units for procedure-revenue code.
					between this service-procedure-		

4416	**Personal car service not allowed on same or overlapping DOS as inpatient or nursing home stay.**	**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.
4417	**Dup drug, diff provider, same drug, 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.
4418	**DME procedure allowed once per year.**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**259**	Frequency of service.
4419	**Suspect dup, same pro, 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.
4420	**Same procedure, overlapping 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.
4421	**Suspect dup for W9998,same billing pro, DOS and billed amount,.**	**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.
4422	**Suspect dup, same pro, DOS, different billed amount.**	**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.
4423	**Overlapping DOS, same pro, modifier space.**	**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.
4424	**Sus dup, overlapping DOS, same pro, anesthesia mod.**	**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.

4425	**Sus dup, overlapping DOS, asst surgeon modifier.**	**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.
4426	**Sus dup,overlapping DOS, primary service modifier.**	**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.
4427	**Sus dup,overlapping DOS, ambulance modifier.**	**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.
4428	**Sus dup,overlapping DOS, prof and tech modifier.**	**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.
4429	**Sus dup,overlapping DOS, ASC modifier.**	**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.
4430	**Sus dup,overlapping DOS, DME or HIT modifier ,.**	**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.
4431	**Sus dup,overlapping DOS, eye modifier,.**	**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.
4432	**Sus dup,overlapping DOS, finger modifier.**	**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.
4433	**Sus dup,overlapping DOS, toes modifier.**	**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.
4434	**Sus dup, overlapping DOS, bilateral proc,.**	**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.
4435	**Dup billing, matching crossover claim recouped,.**	**18**	Exact duplicate claim-service	**N20**	Service not payable with other service rendered on the same date	**54**	Duplicate of a previously processed claim-line.

4436	**Suspect dup, Medicare adjust, same procedure, provider, overlapping 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.
4437	**Hospital region 40 not allowed with AMB SERV Region 10.**	**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.
4439	**Suspect dup, Medicare adjust, same procedure, provider, overlapping 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.
4440	**Suspect dup, overlapping DOS, same procedure, different modifier.**	**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.
4441	**Suspect dup, overlapping DOS, same procedure, different modifier.**	**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.
4442	**Suspect dup, overlapping DOS, same procedure, different modifier.**	**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.
4443	**Suspect dup, overlapping DOS, same procedure, different modifier.**	**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.
4444	**Suspect dup, overlapping DOS, same procedure, different modifier.**	**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.

4445	**Service not allowed while recipient is enrolled in a high risk intervention- Residential hospital.**	**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.
4446	**Service recouped. Recipient is enrolled in a high risk intervention- residential hospital on the 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
4450	**Claim denied as exact duplicate of previously paid claim with the same Medicare ICN.**	**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.
4456	**Claim already paid to Carolina Alternative agency responsible for the recipients county residence.**	**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.
4465	**Personal care service are not allowed when recipient is receiving inpatient services.**	**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.	**M2**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.

4466	**Service recouped. Personal care service not allowed when recipient is receiving inpatient services.**	**B15**	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other	**M2**	Not paid separately when the patient is an inpatient.	**258**	Days-units for procedure-revenue code.
					between this service-procedure-		

4472	**Exceeds 10 units per 270 day limitation.**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4473	**Anesthesia procedure once 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.
4473	**Anesthesia procedure once per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N203**	Missing-incomplete-invalid anesthesia time-units	**259**	Frequency of service.
4473	**Anesthesia procedure once 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
4473	**Anesthesia procedure once per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N203**	Missing-incomplete-invalid anesthesia time-units	**612**	Per Day Limit Amount
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
4477	**Osteotomy procedure allowed one occurrence per day**	**119**	Benefit maximum for this time period or occurrence has been reached		**No Mapping Required**	**259**	Frequency of service.
4477	**Osteotomy procedure allowed one occurrence per day**	**119**	Benefit maximum for this time period or occurrence has been reached		**No Mapping Required**	**612**	Per Day Limit Amount
4478	**Osteotomy and exploration of spine not same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4478	**Osteotomy and exploration of spine not same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4478	**Osteotomy and exploration of spine not same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered

4478	**Osteotomy and exploration of spine not same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4479	**Exploration and Osteotomy of spine not allowed on same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4479	**Exploration and Osteotomy of spine not allowed on same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4479	**Exploration and Osteotomy of spine not allowed on same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4479	**Exploration and Osteotomy of spine not allowed on same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4480	**Add-on procedure must be billed with primary procedure**	**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.	**465**	Principal Procedure Code for Service(s) Rendered
4480	**Add-on procedure must be billed with primary procedure**	**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	**N122**	Add-on code cannot be billed by itself	**465**	Principal Procedure Code for Service(s) Rendered
4481	**Tenotomy not allowed same day as debridement**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4481	**Tenotomy not allowed same day as debridement**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4481	**Tenotomy not allowed same day as debridement**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered

4481	**Tenotomy not allowed same day as debridement**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4482	**Debridement not allowed same day as Tenotomy**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4482	**Debridement not allowed same day as Tenotomy**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4482	**Debridement not allowed same day as Tenotomy**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4482	**Debridement not allowed same day as Tenotomy**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4483	**Related hip procedure not allowed same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4483	**Related hip procedure not allowed same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4483	**Related hip procedure not allowed same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4483	**Related hip procedure not allowed same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4485	**Related repair codes not allowed same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4485	**Related repair codes not allowed same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4485	**Related repair codes not allowed same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered

4485	**Related repair codes not allowed same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4487	**Related fracture procedures not allowed same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4487	**Related fracture procedures not allowed same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4487	**Related fracture procedures not allowed same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4487	**Related fracture procedures not allowed same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4489	**Biceps Tenodesis not allowed same day as related arthroscopy procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4489	**Biceps Tenodesis not allowed same day as related arthroscopy procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4489	**Biceps Tenodesis not allowed same day as related arthroscopy procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4489	**Biceps Tenodesis not allowed same day as related arthroscopy procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4490	**Related arthroscopy procedures not allowed same day as Biceps Tenodesis**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4490	**Related arthroscopy procedures not allowed same day as Biceps Tenodesis**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.

4490	**Related arthroscopy procedures not allowed same day as Biceps Tenodesis**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4490	**Related arthroscopy procedures not allowed same day as Biceps Tenodesis**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4491	**Thoracentesis not allowed same day as related procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4491	**Thoracentesis not allowed same day as related procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4491	**Thoracentesis not allowed same day as related procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4491	**Thoracentesis not allowed same day as related procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4492	**Related procedure not allowed same day as Throacentesis**	**169**	Payment adjusted because an alternate benefit has been provided	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered
4492	**Related procedure not allowed same day as Throacentesis**	**169**	Payment adjusted because an alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered
4493	**Insertion of catheter not allowed same day as related procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4493	**Insertion of catheter not allowed same day as related procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4493	**Insertion of catheter not allowed same day as related procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered

4493	**Insertion of catheter not allowed same day as related procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4494	**Related procedure not allowed same day as insertion of catheter**	**169**	Payment adjusted because an alternate benefit has been provided	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered
4494	**Related procedure not allowed same day as insertion of catheter**	**169**	Payment adjusted because an alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered
4495	**Thoracostomy not allowed same day as excision**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4495	**Thoracostomy not allowed same day as excision**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4495	**Thoracostomy not allowed same day as excision**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4495	**Thoracostomy not allowed same day as excision**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4496	**Escision procedure not allowed same day as Thoracostomy**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4496	**Escision procedure not allowed same day as Thoracostomy**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4496	**Escision procedure not allowed same day as Thoracostomy**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4496	**Escision procedure not allowed same day as Thoracostomy**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4497	**Ablation must be billed with related cardiac procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.

4497	**Ablation must be billed with related cardiac procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4497	**Ablation must be billed with related cardiac procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4497	**Ablation must be billed with related cardiac procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4498	**Related surgical procedure not allowed same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4498	**Related surgical procedure not allowed same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4498	**Related surgical procedure not allowed same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4498	**Related surgical procedure not allowed same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4499	**Units Cutback. Exceeds 10 units per 270 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.
4499	**Units Cutback. Exceeds 10 units per 270 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.
4501	**Aorta graft not allowed same day as related procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4501	**Aorta graft not allowed same day as related procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4501	**Aorta graft not allowed same day as related procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered

4501	**Aorta graft not allowed same day as related procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4502	**Related procedure not allowed same day as Aorta graft**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4502	**Related procedure not allowed same day as Aorta graft**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4502	**Related procedure not allowed same day as Aorta graft**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4502	**Related procedure not allowed same day as Aorta graft**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4503	**Transcatheter must be billed with related repair procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4503	**Transcatheter must be billed with related repair procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4503	**Transcatheter must be billed with related repair procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4503	**Transcatheter must be billed with related repair procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4504	**Bypass graft procedure not allowed same day as related procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4504	**Bypass graft procedure not allowed same day as related procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4504	**Bypass graft procedure not allowed same day as related procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered

4504	**Bypass graft procedure not allowed same day as related procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4505	**Related procedure not allowed same day as bypass graft**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4505	**Related procedure not allowed same day as bypass graft**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4505	**Related procedure not allowed same day as bypass graft**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4505	**Related procedure not allowed same day as bypass graft**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4506	**Excision of tumors not allowed same day as related surgical procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4506	**Excision of tumors not allowed same day as related surgical procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4506	**Excision of tumors not allowed same day as related surgical procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4506	**Excision of tumors not allowed same day as related surgical procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4507	**Related surgical procedure not allowed same day as excision of tumors**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4507	**Related surgical procedure not allowed same day as excision of tumors**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4507	**Related surgical procedure not allowed same day as excision of tumors**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered

4507	**Related surgical procedure not allowed same day as excision of tumors**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4510	**Gastric tube placement not allowed same day as related insertion procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4510	**Gastric tube placement not allowed same day as related insertion procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4510	**Gastric tube placement not allowed same day as related insertion procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4510	**Gastric tube placement not allowed same day as related insertion procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4511	**Insertion procedure not allowed same day as gastric tube placement. Gastric tube placement recouped.**	**169**	Payment adjusted because an alternate benefit has been provided	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
4511	**Insertion procedure not allowed same day as gastric tube placement. Gastric tube placement recouped.**	**169**	Payment adjusted because an alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4511	**Insertion procedure not allowed same day as gastric tube placement. Gastric tube placement recouped.**	**169**	Payment adjusted because an alternate benefit has been provided	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**490**	Other Procedure Code for Service(s) Rendered
4511	**Insertion procedure not allowed same day as gastric tube placement. Gastric tube placement recouped.**	**169**	Payment adjusted because an alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4512	**Mechanical removal or contrast injection not allowed same day as replacement procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.

4512	**Mechanical removal or contrast injection not allowed same day as replacement procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4512	**Mechanical removal or contrast injection not allowed same day as replacement procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4512	**Mechanical removal or contrast injection not allowed same day as replacement procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4513	**Replacement procedure not allowed same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4513	**Replacement procedure not allowed same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4513	**Replacement procedure not allowed same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4513	**Replacement procedure not allowed same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4514	**Mechanical removal not allowed same day as insertion contrast**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4514	**Mechanical removal not allowed same day as insertion contrast**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4514	**Mechanical removal not allowed same day as insertion contrast**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4514	**Mechanical removal not allowed same day as insertion contrast**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered

4515	**Contrast injection not allowed same day as mechanical removal**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4515	**Contrast injection not allowed same day as mechanical removal**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**454**	Procedure code for services rendered.
4515	**Contrast injection not allowed same day as mechanical removal**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**490**	Other Procedure Code for Service(s) Rendered
4515	**Contrast injection not allowed same day as mechanical removal**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**490**	Other Procedure Code for Service(s) Rendered
4517	**Additional augmentation requires initial procedure**	**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.	**454**	Procedure code for services rendered.
4517	**Additional augmentation requires initial procedure**	**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	**N122**	Add-on code cannot be billed by itself.	**454**	Procedure code for services rendered.
4517	**Additional augmentation requires initial procedure**	**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	**454**	Procedure code for services rendered.
4520	**Anesthesia Assistant services not allowed same day as related anesthesia procedure.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

4520	**Anesthesia Assistant services not allowed same day as related anesthesia procedure.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4520	**Anesthesia Assistant services not allowed same day as related anesthesia procedure.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4520	**Anesthesia Assistant services not allowed same day as related anesthesia procedure.**	**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 .
4520	**Anesthesia Assistant services not allowed same day as related anesthesia procedure.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered .
4520	**Anesthesia Assistant services not allowed same day as related anesthesia procedure.**	**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 .
4521	**Related anesthesia services not allowed same day as anesthesia assistant services.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4521	**Related anesthesia services not allowed same day as anesthesia assistant services.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4521	**Related anesthesia services not allowed same day as anesthesia assistant services.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4521	**Related anesthesia services not allowed same day as anesthesia assistant services.**	**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 .
4521	**Related anesthesia services not allowed same day as anesthesia assistant services.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered .

4521	**Related anesthesia services not allowed same day as anesthesia assistant services.**	**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 .
4522	**Anesthesia stand by not allowed on the same day as an anesthesia procedure.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4522	**Anesthesia stand by not allowed on the same day as an anesthesia procedure.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4522	**Anesthesia stand by not allowed on the same day as an anesthesia procedure.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4522	**Anesthesia stand by not allowed on the same day as an anesthesia procedure.**	**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 .
4522	**Anesthesia stand by not allowed on the same day as an anesthesia procedure.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered .
4522	**Anesthesia stand by not allowed on the same day as an anesthesia procedure.**	**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 .
4523	**Anesthesia procedure not allowed same day as anesthesia stand by procedure.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4523	**Anesthesia procedure not allowed same day as anesthesia stand by procedure.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4523	**Anesthesia procedure not allowed same day as anesthesia stand by procedure.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.

4523	**Anesthesia procedure not allowed same day as anesthesia stand by procedure.**	**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 .
4523	**Anesthesia procedure not allowed same day as anesthesia stand by procedure.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered .
4523	**Anesthesia procedure not allowed same day as anesthesia stand by procedure.**	**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 .
4524	**Only 1 hour of anesthesia stand by allowed per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4524	**Only 1 hour of anesthesia stand by 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.	**187**	Date(s) of service.
4524	**Only 1 hour of anesthesia stand by allowed per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered
4524	**Only 1 hour of anesthesia stand by 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.	**454**	Procedure code for services rendered
4549	**Service denied. Sandhill's MCO services prior to date of service 12/01/2012**	**A1**	Claim-Service denied	**N182**	This claim-service must be billed according to the schedule for this plan	**91**	Entity not eligible-not approved for dates of service
4550	**Claim denied. Sandhills outpatient claim is older than 90 days**	**A1**	Claim-Service denied	**N182**	This claim-service must be billed according to the schedule for this plan	**718**	Claim-service not submitted within the required timeframe
4551	**Claim denied. Sandhills inpatient claim is older than 180 days**	**A1**	Claim-Service denied	**N182**	This claim-service must be billed according to the schedule for this plan	**718**	Claim-service not submitted within the required timeframe

4552	**Claim Denied. Recipient's category of aid is not a covered eligibillity code for Sandhills Center**	**A1**	Claim-Service denied	**N180**	This item or service does not meet the criteria for the category under which it was billed	**25**	Entity not approved
4612	**Subcutaneous infusion add-on code must be billed with primary 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.	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered
4612	**Subcutaneous infusion add-on code must be billed with primary 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.	**N122**	Add-on code cannot be billed by itself	**454**	Procedure code for services rendered
4613	**Only one initial infusion 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.
4613	**Only one initial infusion 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
4614	**Only one additional pump set-up 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.
4614	**Only one additional pump set-up 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

4615	**Procedure denied, not allowed same day as related Lab procedure**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4615	**Procedure denied, not allowed same day as related Lab procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4615	**Procedure denied, not allowed same day as related Lab procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4615	**Procedure denied, not allowed same day as related Lab procedure**	**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
4615	**Procedure denied, not allowed same day as related Lab procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4615	**Procedure denied, not allowed same day as related Lab procedure**	**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
4616	**Procedure recouped, not allowed same day as related Lab procedure**	**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.	**187**	Date(s) of service.
4616	**Procedure recouped, not allowed same day as related Lab procedure**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.

4616	**Procedure recouped, not allowed same day as related Lab procedure**	**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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4616	**Procedure recouped, not allowed same day as related Lab procedure**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4616	**Procedure recouped, not allowed same day as related Lab procedure**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4616	**Procedure recouped, not allowed same day as related Lab procedure**	**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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4617	**Service denied. Basic Metabolic Panel not allowed same day as Comprehensive Panel**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

4617	**Service denied. Basic Metabolic Panel not allowed same day as Comprehensive Panel**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4617	**Service denied. Basic Metabolic Panel not allowed same day as Comprehensive Panel**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4617	**Service denied. Basic Metabolic Panel not allowed same day as Comprehensive Panel**	**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
4617	**Service denied. Basic Metabolic Panel not allowed same day as Comprehensive Panel**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4617	**Service denied. Basic Metabolic Panel not allowed same day as Comprehensive Panel**	**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
4618	**Basic Metabolic Panel recouped to allowe reimbursement of Comprehensive 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.	**187**	Date(s) of service.
4618	**Basic Metabolic Panel recouped to allowe reimbursement of Comprehensive 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.

4618	**Basic Metabolic Panel recouped to allowe reimbursement of Comprehensive 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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4618	**Basic Metabolic Panel recouped to allowe reimbursement of Comprehensive 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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4618	**Basic Metabolic Panel recouped to allowe reimbursement of Comprehensive 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4618	**Basic Metabolic Panel recouped to allowe reimbursement of Comprehensive 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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4619	**Service denied. Basic Metabolic Panel includes procedure as a component of the panel**	**A1**	Claim-Service denied	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**453**	Procedure Code Modifier(s) for Service(s) Rendered

4619	**Service denied. Basic Metabolic Panel includes procedure as a component of the panel**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4619	**Service denied. Basic Metabolic Panel includes procedure as a component of the panel**	**A1**	Claim-Service denied	**M126**	Missing-incomplete-invalid individual lab codes included in the test.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4620	**Component of Basic Metabolic Panel recouped to allow reimbursement of 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.	**M15**	M15 - Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4620	**Component of Basic Metabolic Panel recouped to allow reimbursement of 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4620	**Component of Basic Metabolic Panel recouped to allow reimbursement of 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.	**M126**	Missing-incomplete-invalid individual lab codes included in the test.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4621	**Service denied. Related procedure not allowed same day as cardiac MRI procedure**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

4621	**Service denied. Related procedure not allowed same day as cardiac MRI procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4621	**Service denied. Related procedure not allowed same day as cardiac MRI procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4621	**Service denied. Related procedure not allowed same day as cardiac MRI procedure**	**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
4621	**Service denied. Related procedure not allowed same day as cardiac MRI procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4621	**Service denied. Related procedure not allowed same day as cardiac MRI procedure**	**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
4622	**Service recouped. Cardiac MRI procedure and related procedure not allowed same day**	**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.	**187**	Date(s) of service.
4622	**Service recouped. Cardiac MRI procedure and related procedure not allowed same day**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.

4622	**Service recouped. Cardiac MRI procedure and related procedure not allowed same day**	**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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4622	**Service recouped. Cardiac MRI procedure and related procedure not allowed same day**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4622	**Service recouped. Cardiac MRI procedure and related procedure not allowed same day**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4622	**Service recouped. Cardiac MRI procedure and related procedure not allowed same day**	**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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4623	**Service denied. Related cardiac procedures not allowed same day**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

4623	**Service denied. Related cardiac procedures not allowed same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4623	**Service denied. Related cardiac procedures not allowed same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4623	**Service denied. Related cardiac procedures not allowed same day**	**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
4623	**Service denied. Related cardiac procedures not allowed same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4623	**Service denied. Related cardiac procedures not allowed same day**	**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
4624	**Service denied. Nasolacrimal Duct Probe procedure not allowed same day as related procedure**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4624	**Service denied. Nasolacrimal Duct Probe procedure not allowed same day as related procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4624	**Service denied. Nasolacrimal Duct Probe procedure not allowed same day as related procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4624	**Service denied. Nasolacrimal Duct Probe procedure not allowed same day as related procedure**	**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

4624	**Service denied. Nasolacrimal Duct Probe procedure not allowed same day as related procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4624	**Service denied. Nasolacrimal Duct Probe procedure not allowed same day as related procedure**	**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
4625	**Service denied. Related procedure not allowed same day as Nasolacrimal Duct Probe procedure**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4625	**Service denied. Related procedure not allowed same day as Nasolacrimal Duct Probe procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4625	**Service denied. Related procedure not allowed same day as Nasolacrimal Duct Probe procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4625	**Service denied. Related procedure not allowed same day as Nasolacrimal Duct Probe procedure**	**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
4625	**Service denied. Related procedure not allowed same day as Nasolacrimal Duct Probe procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4625	**Service denied. Related procedure not allowed same day as Nasolacrimal Duct Probe procedure**	**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
4626	**Service denied. Laser procedure of prostate not allowed same day as related procedure**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

4626	**Service denied. Laser procedure of prostate not allowed same day as related procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4626	**Service denied. Laser procedure of prostate not allowed same day as related procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4626	**Service denied. Laser procedure of prostate not allowed same day as related procedure**	**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
4626	**Service denied. Laser procedure of prostate not allowed same day as related procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4626	**Service denied. Laser procedure of prostate not allowed same day as related procedure**	**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
4627	**Service denied. Related procedure not allowed same day as laser procedure of prostate**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4627	**Service denied. Related procedure not allowed same day as laser procedure of prostate**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4627	**Service denied. Related procedure not allowed same day as laser procedure of prostate**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4627	**Service denied. Related procedure not allowed same day as laser procedure of prostate**	**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
4627	**Service denied. Related procedure not allowed same day as laser procedure of prostate**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered

4627	**Service denied. Related procedure not allowed same day as laser procedure of prostate**	**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
4628	**Service denied. Laparoscopic hysterectomy not allowed same day as abdominal hysterectomy**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4628	**Service denied. Laparoscopic hysterectomy not allowed same day as abdominal hysterectomy**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4628	**Service denied. Laparoscopic hysterectomy not allowed same day as abdominal hysterectomy**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4628	**Service denied. Laparoscopic hysterectomy not allowed same day as abdominal hysterectomy**	**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
4628	**Service denied. Laparoscopic hysterectomy not allowed same day as abdominal hysterectomy**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4628	**Service denied. Laparoscopic hysterectomy not allowed same day as abdominal hysterectomy**	**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
4629	**Service denied. Abdominal hysterectomy not allowed same day as laparoscopic hysterectomy**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4629	**Service denied. Abdominal hysterectomy not allowed same day as laparoscopic hysterectomy**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.

4629	**Service denied. Abdominal hysterectomy not allowed same day as laparoscopic hysterectomy**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4629	**Service denied. Abdominal hysterectomy not allowed same day as laparoscopic hysterectomy**	**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
4629	**Service denied. Abdominal hysterectomy not allowed same day as laparoscopic hysterectomy**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4629	**Service denied. Abdominal hysterectomy not allowed same day as laparoscopic hysterectomy**	**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
4630	**Service denied. Related surgical procedure not allowed same day as laparoscopic hysterectomy**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4630	**Service denied. Related surgical procedure not allowed same day as laparoscopic hysterectomy**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4630	**Service denied. Related surgical procedure not allowed same day as laparoscopic hysterectomy**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4630	**Service denied. Related surgical procedure not allowed same day as laparoscopic hysterectomy**	**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
4630	**Service denied. Related surgical procedure not allowed same day as laparoscopic hysterectomy**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4630	**Service denied. Related surgical procedure not allowed same day as laparoscopic hysterectomy**	**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

4631	**Service recouped. Laparoscopic hysterectomy and related surgical procedure not allowed same date of 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.	**187**	Date(s) of service.
4631	**Service recouped. Laparoscopic hysterectomy and related surgical procedure not allowed same date of 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4631	**Service recouped. Laparoscopic hysterectomy and related surgical procedure not allowed same date of 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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4631	**Service recouped. Laparoscopic hysterectomy and related surgical procedure not allowed same date of 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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered

4631	**Service recouped. Laparoscopic hysterectomy and related surgical procedure not allowed same date of 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4631	**Service recouped. Laparoscopic hysterectomy and related surgical procedure not allowed same date of 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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4634	**Service denied. Paravaginal Defect Repair not allowed same day as related surgical procedure**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4634	**Service denied. Paravaginal Defect Repair not allowed same day as related surgical procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4634	**Service denied. Paravaginal Defect Repair not allowed same day as related surgical procedure**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4634	**Service denied. Paravaginal Defect Repair not allowed same day as related surgical procedure**	**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
4634	**Service denied. Paravaginal Defect Repair not allowed same day as related surgical procedure**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered

4634	**Service denied. Paravaginal Defect Repair not allowed same day as related surgical procedure**	**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
4635	**Service denied. Related surgical procedure not allowed same day as Paravaginal Defect Repair**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4635	**Service denied. Related surgical procedure not allowed same day as Paravaginal Defect Repair**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4635	**Service denied. Related surgical procedure not allowed same day as Paravaginal Defect Repair**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4635	**Service denied. Related surgical procedure not allowed same day as Paravaginal Defect Repair**	**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
4635	**Service denied. Related surgical procedure not allowed same day as Paravaginal Defect Repair**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4635	**Service denied. Related surgical procedure not allowed same day as Paravaginal Defect Repair**	**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
4636	**Service denied. Related procedure included in laser procedure of Prostate Complete**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4636	**Service denied. Related procedure included in laser procedure of Prostate Complete**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4636	**Service denied. Related procedure included in laser procedure of Prostate Complete**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.

4636	**Service denied. Related procedure included in laser procedure of Prostate Complete**	**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
4636	**Service denied. Related procedure included in laser procedure of Prostate Complete**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4636	**Service denied. Related procedure included in laser procedure of Prostate Complete**	**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
4637	**Service recouped. Laser procedure of prostate includes related procedure**	**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.	**187**	Date(s) of service.
4637	**Service recouped. Laser procedure of prostate includes related procedure**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4637	**Service recouped. Laser procedure of prostate includes related procedure**	**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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.

4637	**Service recouped. Laser procedure of prostate includes related procedure**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4637	**Service recouped. Laser procedure of prostate includes related procedure**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4637	**Service recouped. Laser procedure of prostate includes related procedure**	**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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
4638	**Moderate sedation services not allowed on same date of service as related procedures when performed in an office.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4638	**Moderate sedation services not allowed on same date of service as related procedures when performed in an office.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4638	**Moderate sedation services not allowed on same date of service as related procedures when performed in an office.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.

4638	**Moderate sedation services not allowed on same date of service as related procedures when performed in an office.**	**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.
4638	**Moderate sedation services not allowed on same date of service as related procedures when performed in an office.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
4638	**Moderate sedation services not allowed on same date of service as related procedures when performed in an office.**	**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.
4639	**Related procedure not allowed on same date of service as Moderate sedation services when performed in an office.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4639	**Related procedure not allowed on same date of service as Moderate sedation services when performed in an office.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4639	**Related procedure not allowed on same date of service as Moderate sedation services when performed in an office.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4639	**Related procedure not allowed on same date of service as Moderate sedation services when performed in an office.**	**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.

4639	**Related procedure not allowed on same date of service as Moderate sedation services when performed in an office.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
4639	**Related procedure not allowed on same date of service as Moderate sedation services when performed in an office.**	**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.
4640	**Moderate sedation service not allowed on same date of Service as related procedures when performed by same Attending provider.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4640	**Moderate sedation service not allowed on same date of Service as related procedures when performed by same Attending provider.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	
4640	**Moderate sedation service not allowed on same date of Service as related procedures when performed by same Attending provider.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	
4640	**Moderate sedation service not allowed on same date of Service as related procedures when performed by same Attending 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.

4640	**Moderate sedation service not allowed on same date of Service as related procedures when performed by same Attending provider.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
4640	**Moderate sedation service not allowed on same date of Service as related procedures when performed by same Attending 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.
4641	**Related procedure not allowed on same date of service as Moderate sedation services when performed by same Attending provider .**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4641	**Related procedure not allowed on same date of service as Moderate sedation services when performed by same Attending provider .**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4641	**Related procedure not allowed on same date of service as Moderate sedation services when performed by same Attending provider .**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4641	**Related procedure not allowed on same date of service as Moderate sedation services when performed by same Attending 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.

4641	**Related procedure not allowed on same date of service as Moderate sedation services when performed by same Attending provider .**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
4641	**Related procedure not allowed on same date of service as Moderate sedation services when performed by same Attending 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.
4642	**Moderate sedation service not allowed on same date of Service as related sedation procedures.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4642	**Moderate sedation service not allowed on same date of Service as related sedation procedures.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4642	**Moderate sedation service not allowed on same date of Service as related sedation procedures.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4642	**Moderate sedation service not allowed on same date of Service as related sedation procedures.**	**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.
4642	**Moderate sedation service not allowed on same date of Service as related sedation procedures.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
4642	**Moderate sedation service not allowed on same date of Service as related sedation procedures.**	**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.

4643	**Related sedation procedure not allowed on same date of service as moderate sedation services.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4643	**Related sedation procedure not allowed on same date of service as moderate sedation services.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4643	**Related sedation procedure not allowed on same date of service as moderate sedation services.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
4643	**Related sedation procedure not allowed on same date of service as moderate sedation services.**	**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.
4643	**Related sedation procedure not allowed on same date of service as moderate sedation services.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
4643	**Related sedation procedure not allowed on same date of service as moderate sedation services.**	**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.
4647	**TCM/DD Procedure not allowed same calendar week as other treatment/service already rendered by other provider.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
4648	**Other Treatment/service procedure not allowed when TCM/DD is rendered same calendar week by other provider.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.

4649	**Service denied. Procedure code/modifier combination not allowed for place of service billed, if 60 days have expired from when TCM/DD service was rendered.**	**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
4772	**Orthotic or Prosthetic Equipment allowed once per two years for ages 003-115. Units cutback to allowed amount.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N129**	Not eligible due to the patients age.	**258**	Days-units for procedure-revenue code.
4772	**Orthotic or Prosthetic Equipment allowed once per two years for ages 003-115. Units cutback to allowed amount.**	**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.
4772	**Orthotic or Prosthetic Equipment allowed once per two years for ages 003-115. Units cutback to allowed amount.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N129**	Not eligible due to the patients age.	**259**	Frequency of service.
4772	**Orthotic or Prosthetic Equipment allowed once per two years for ages 003-115. Units cutback to allowed amount.**	**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.
4780	**Service denied. Differing Hyaluronan injections not allowed on the same day**	**A1**	Claim-Service denied	**M80**	M80 - Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4780	**Service denied. Differing Hyaluronan injections not allowed on the same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
4780	**Service denied. Differing Hyaluronan injections not allowed on the same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.

4780	**Service denied. Differing Hyaluronan injections not allowed on the same day**	**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.
4780	**Service denied. Differing Hyaluronan injections not allowed on the same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered.
4780	**Service denied. Differing Hyaluronan injections not allowed on the same day**	**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.
4780	**Service denied. Differing Hyaluronan injections not allowed on the same day**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**612**	Per Day Limit Amount
4780	**Service denied. Differing Hyaluronan injections not allowed on the same day**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
4780	**Service denied. Differing Hyaluronan injections not allowed on the same day**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**612**	Per Day Limit Amount
4782	**Adjustment denied. Multiple PCS providers are billing for PCS Services. Claim has been sent to DMA for additional review.**	**A1**	Claim-Service denied	**N10**	Payment based on the findings of a review organization-professional consult-manual adjudication-medical or dental advisor.	**107**	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)
4789	**Papilloma virus vaccine allowed once per day same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
4789	**Papilloma virus vaccine allowed once per day same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
4790	**PAPILLOMA VIRUS VACCINE ALLOWED 3 PER LIFETIME SAME OR DIFFERENT PROVIDER**	**149**	Lifetime benefit maximum has been reached for this service-benefit category.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

4791	**VACCINE ALLOWED ONLY 3 TIMES PER LIFETIME SAME OR DIFFERENT PROVIDER**	**149**	Lifetime benefit maximum has been reached for this service-benefit category.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
4798	**H0040 not allowed same date of service with other Enhanced Benefit Services**	**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.	**187**	Date (s) of service. .
4798	**H0040 not allowed same date of service with other Enhanced Benefit Services**	**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.	**259**	Frequency of service
4798	**H0040 not allowed same date of service with other Enhanced Benefit Services**	**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

4799	**Service denied. Maximum allowed units per waiver year for this CAPMR service billed by the same or different provider have been exceeded**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service
4800	**The maximum allowed monetary limitation per waiver year for the CAP/CH service billed by same or different provider has been exceeded**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
4801	**The maximum allowed monetary limitation for the CAP/CH service billed by same or different provider has been exceeded for the allowed 5 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
4802	**The maximum allowed unit limitation per waiver year for CAP/CH service billed by same or different provider has been exceeded**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
4803	**Maximum allowed units per day for CAP/CH servces billed by same or different provider has been exceeded**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service
4803	**Maximum allowed units per day for CAP/CH servces billed by same or different provider has been exceeded**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
4804	**Maximum allowed number of occurrences per waiver year for CAP/CH service billed by same or different provider has been exceeded**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service

4805	**ONLY ONE OCCURRENCE ALLOWED FOR CAP/CH SERVICE PER RECIPIENT'S LIFETIME**	**119**	Benefit maximum for this time period or occurrence has been reached	**N117**	This service is paid only once in a patients lifetime.	**259**	Frequency of service
4805	**ONLY ONE OCCURRENCE ALLOWED FOR CAP/CH SERVICE PER RECIPIENT'S LIFETIME**	**119**	Benefit maximum for this time period or occurrence has been reached	**N117**	This service is paid only once in a patients lifetime.	**483**	Maximum coverage amount met or exceeded for benefit period.
4806	**CAP/CH SERVICE NOT ALLOWED SAME DAY AS HOSPICE SERVICE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
4806	**CAP/CH SERVICE NOT ALLOWED SAME DAY AS HOSPICE SERVICE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
4807	**SERVICE DENIED. UNIT LIMITATION HAS BEEN EXCEEDED FOR THIS SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code.
4808	**CAP/CH SERVICE RECOUPED, NOT ALLOWED SAME DAY AS HOSPICE 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.
4807	**Service denied. Unit limitation has been exceeded for this service**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service
4832	**Dispensing of Fuzeon is limited to once per month**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
4833	**Units cutback. Refile as an adjustment with appropriate documentation to support units.**	**119**	Benefit maximum for this time period or occurrence has been reached		**No Mapping Required**	**259**	Frequency of service.

4833	**Units cutback. Refile as an adjustment with appropriate documentation to support units.**	**119**	Benefit maximum for this time period or occurrence has been reached		**No Mapping Required**	**294**	Supporting documentation.
4834	**Service denied. Refile as adjustment with appropriate documentation to support procedure**	**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.	**258**	Days-units for procedure-revenue code.
4834	**Service denied. Refile as adjustment with appropriate documentation to support procedure**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
4839	**Service denied. Diagnosis does not support units billed. If units are correct, review for appropriate diagnosis, correct and resubmit as a new day claim**	**125**	Submission-billing error(s)	**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.
4840	**Transportation of portable x-ray equipment is limited to 2 trips 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.
4840	**Transportation of portable x-ray equipment is limited to 2 trips 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
4841	**Orthotic or prosthetic equipment allowed once every 6 months for ages 000-020**	**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.
4841	**Orthotic or prosthetic equipment allowed once every 6 months for ages 000-020**	**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
4842	**Orthotic or prosthetic equipment allowed 3 per foot per year for ages 000-020**	**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.

4842	**Orthotic or prosthetic equipment allowed 3 per foot per year for ages 000-020**	**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
4843	**Orthotic or prosthetic equipment allowed 4 every 6 months for ages 000-020**	**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.
4843	**Orthotic or prosthetic equipment allowed 4 every 6 months for ages 000-020**	**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
4844	**Orthotic or prosthetic equipment allowed once in three years for ages 000-020**	**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.
4844	**Orthotic or prosthetic equipment allowed once in three years for ages 000-020**	**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
4845	**Orthotic or prosthetic equipment allowed four per year for ages 000-020**	**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.
4845	**Orthotic or prosthetic equipment allowed four per year for ages 000-020**	**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
4846	**Orthotic or prosthetic equipment allowed six per year for ages 000-020**	**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.
4847	**Orthotic or prosthetic equipment allowed twelve per year for ages 000-020**	**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.
4848	**Orthotic or prosthetic equipment allowed one per two years, ages 000-020**	**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.

4849	**Orthotic or prosthetic equipment allowed twice in one year, ages 000-020**	**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.
4850	**Orthotic or prosthetic equipment allowed once per year for ages 000-020**	**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.
4851	**Orthotic or prosthetic equipment allowed 2 per foot per year for ages 000-020**	**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.
4852	**Orthotic or prosthetic equipment allowed twice every 6 months for ages 000-020**	**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.
4853	**Orthotic or prosthetic equipment allowed once every two years for ages 021-115**	**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.
4854	**Orthotic or prosthetic equipment allowed once every six months for ages 021-115**	**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.
4855	**Orthotic or prosthetic equipment allowed once per five years for ages 021-115**	**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.
4856	**Orthotic or prosthetic equipment allowed four per year for ages 021-115**	**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.
4857	**Orthotic or prosthetic equipment allowed once every three years for ages 021-115**	**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.
4858	**Orthotic or prosthetic equipment allowed two per year for ages 021-115**	**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.

4859	**Orthotic or prosthetic equipment allowed once per year for ages 021-115**	**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.
4860	**Orthotic or prosthetic equipment allowed two every six months for ages 021-115**	**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.
4861	**Orthotic or prosthetic equipment allowed two per foot, per year for ages 021-115**	**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.
4862	**Orthotic or prosthetic equipment allowed six per year for ages 021-115**	**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.
4863	**Orthotic or prosthetic equipment allowed three per foot, per year for ages 021-115**	**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.
4864	**Orthotic or prosthetic equipment allowed twelve per year for ages 021-115**	**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.
4865	**Orthotic and prosthetic equipment allowed two per limb every 6 months for ages 000-020**	**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.
4868	**Orthotic and prosthetic equipment allowed two per limb every 3 years for ages 021-115**	**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.
4869	**Orthotic and prosthetic equipment allowed four per limb every 6 months for ages 000-020**	**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.
4870	**Orthotic and prosthetic equipment allowed four per limb every 3 years for ages 021-115**	**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.

4871	**Orthotic and prosthetic equipment allowed two per limb per 1 year for ages 000-020**	**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.
4872	**Orthotic and prosthetic equipment allowed two per limb per 1 year for ages 021-115**	**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.
4877	**Units Cutback. Exceeds 10 units per 270 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.
4878	**Surgical procedures limited to 20 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.
4879	**Units cutback. Exceeds maximum units per day.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
4950	**Money follows the person (MFP) service not allowed same day as inpatient claim**	**A1**	Claim-Service denied	**MA133**	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	**187**	Date(s) of service.
4950	**Money follows the person (MFP) service not allowed same day as inpatient claim**	**A1**	Claim-Service denied	**M2**	Not paid separately when the patient is an inpatient.	**187**	Date(s) of service.
4950	**Money follows the person (MFP) service not allowed same day as inpatient claim**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4950	**Money follows the person (MFP) service not allowed same day as inpatient claim**	**A1**	Claim-Service denied	**MA133**	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	**454**	Procedure code for services rendered.
4950	**Money follows the person (MFP) service not allowed same day as inpatient claim**	**A1**	Claim-Service denied	**M2**	Not paid separately when the patient is an inpatient.	**454**	Procedure code for services rendered.
4950	**Money follows the person (MFP) service not allowed same day as inpatient claim**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.

4951	**Inpatient and money follows the person (MFP) services not allowed on same day**	**169**	Alternate benefit has been provided.	**MA133**	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	**187**	Date(s) of service.
4951	**Inpatient and money follows the person (MFP) services not allowed on same day**	**169**	Alternate benefit has been provided.	**M2**	Not paid separately when the patient is an inpatient.	**187**	Date(s) of service.
4951	**Inpatient and money follows the person (MFP) services not allowed on same day**	**169**	Alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
4951	**Inpatient and money follows the person (MFP) services not allowed on same day**	**169**	Alternate benefit has been provided.	**MA133**	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	**454**	Procedure code for services rendered.
4951	**Inpatient and money follows the person (MFP) services not allowed on same day**	**169**	Alternate benefit has been provided.	**M2**	Not paid separately when the patient is an inpatient.	**454**	Procedure code for services rendered.
4951	**Inpatient and money follows the person (MFP) services not allowed on same day**	**169**	Alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
4961	**Units cutback to the amount allowed 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.
4963	**Units cutback to the amount allowed per calendar week without prior approval.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
4965	**Related eye treatment procedure codes cannot be billed on the same claim by the same provider**	**96**	Non-covered charge(s). 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 tiem frame.	**454**	Procedure code for service rendered.
5001	**PA # FOR STATE TO STATE PLACEMENT IS MISSING OR INVALID. CORRECT YOUR PA # AND RESUBMIT**	**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.

5001	**PA # FOR STATE TO STATE PLACEMENT IS MISSING OR INVALID. CORRECT YOUR PA # AND RESUBMIT**	**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.	**252**	Authorization-certification number.
5002	**The HCPC codes(s) billed do not require prior approval. Please refer to the 1995 manual for the correct state to state placement codes.**	**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.
5003	**Units Cutback. Only one procedure or procedure/modifier combination 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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
5003	**Units Cutback. Only one procedure or procedure/modifier combination allowed per day**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
5003	**Units Cutback. Only one procedure or procedure/modifier combination 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
5003	**Units Cutback. Only one procedure or procedure/modifier combination allowed per day**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5007	**Service Denied. Exceeds maximum units allowed per week for same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5008	**Units cutback to the maximum units allowed per week for same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.

5009	**Service Denied. Only one procedure or procedure/modifier combination 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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
5009	**Service Denied. Only one procedure or procedure/modifier combination allowed per day**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
5009	**Service Denied. Only one procedure or procedure/modifier combination 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
5009	**Service Denied. Only one procedure or procedure/modifier combination allowed per day**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5017	**Service Denied. Exceeds Maximum 4 units allowed per 270 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.
5018	**Units Cutback. Units billed exceed maximum units allowed**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5020	**The maximum allowed monetary limitation per waiver year for this CAPMR/DD service has been exceeded**	**45**	**Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement**	**M139**	Denied services exceed the coverage limit for the demonstration.	**483**	Maximum coverage amount met or exceeded for benefit period.
5065	**Service denied. Personal Care Services not allowed the same day as hospice.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5066	**Service recouped. Personal Care Service not allowed the same day as hospice.**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

5067	**Service denied. Personal Care Services not allowed the same day as High Risk Intervention (HRI)-RI facility**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5068	**Service recouped. Personal Care Service not allowed the same day as high risk intervention (HRI)**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5069	**Service denied. Personal Care Services not allowed the same day as CAP services.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5070	**Service recouped. Personal Care Service not allowed the same day as home health service.**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5071	**Service denied. In Home Care (IHC) services not allowed same day as adult care home personal care services (PCS)**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
5072	**Service recouped. In Home Care (IHC) service not allowed same day as adult care home personal care services (PCS)**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5078	**IHCA LIMITED TO 320 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**483**	Maximum coverage amount met or exceeded for benefit period.
5079	**Service denied. Personal Care Services not allowed same day as CAP services**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

5080	**Service recouped. Personal Care Services are not allowed the same date of service as CAP Attendant Care Service**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5100	**Service denied. Drug limited to maximum allowed units per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
5100	**Service denied. Drug limited to maximum allowed units per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5103	**Injection for NON-ESRD use not allowed same date of service as injection for ESRD use, on dialysis.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5103	**Injection for NON-ESRD use not allowed same date of service as injection for ESRD use, on dialysis.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5103	**Injection for NON-ESRD use not allowed same date of service as injection for ESRD use, on dialysis.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5103	**Injection for NON-ESRD use not allowed same date of service as injection for ESRD use, on dialysis.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5104	**Injection for ESRD use, on dialysis not allowed same date of service as injection for NON-ESRD use.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5104	**Injection for ESRD use, on dialysis not allowed same date of service as injection for NON-ESRD use.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.

5104	**Injection for ESRD use, on dialysis not allowed same date of service as injection for NON-ESRD use.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5104	**Injection for ESRD use, on dialysis not allowed same date of service as injection for NON-ESRD use.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5105	**Drug limited to maximum allowed units per calendar month. Units cutback to allowed amount.**	**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.
5105	**Drug limited to maximum allowed units per calendar month. Units cutback to allowed amount.**	**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.	**258**	Days-units for procedure-revenue code.
5105	**Drug limited to maximum allowed units per calendar month. Units cutback to allowed amount.**	**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.
5105	**Drug limited to maximum allowed units per calendar month. Units cutback to allowed amount.**	**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.
5108	**Service denied. Drug limited to 1000 units per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
5108	**Service denied. Drug limited to 1000 units per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code.
5108	**Service denied. Drug limited to 1000 units per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
5108	**Service denied. Drug limited to 1000 units per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**585**	Denied Charge or Non-covered Charge

5109	**Drug limited to 1000 units per calendar month. Units cutback to allowed amount.**	**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.
5109	**Drug limited to 1000 units per calendar month. Units cutback to allowed amount.**	**119**	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.
5109	**Drug limited to 1000 units per calendar month. Units cutback to allowed amount.**	**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.	**585**	Denied Charge or Non-covered Charge
5109	**Drug limited to 1000 units per calendar month. Units cutback to allowed amount.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**585**	Denied Charge or Non-covered Charge
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.
5115	**Service denied. Drug limited to maximum allowed units per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
5115	**Service denied. Drug limited to maximum allowed units per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5115	**Service denied. Drug limited to maximum allowed units per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
5115	**Service denied. Drug limited to maximum allowed units per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**585**	Denied Charge or Non-covered Charge
5116	**Drug limited to maximum allowed units per calendar month. Units cutback to allowed amount.**	**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.
5116	**Drug limited to maximum allowed units per calendar month. Units cutback to allowed amount.**	**119**	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.

5116	**Drug limited to maximum allowed units per calendar month. Units cutback to allowed amount.**	**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.	**585**	Denied Charge or Non-covered Charge
5116	**Drug limited to maximum allowed units per calendar month. Units cutback to allowed amount.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**585**	Denied Charge or Non-covered Charge
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	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
	Variable claim format 3.2 or later						

5121	**For an early refill PRO-DUR Alert override, you must use the prescriber denial clarification field available in claim format 3.2 or later.**	**125**	Submission-billing error(s)	**N34**	Incorrect claim form-format for this service.	**481**	Claim-submission format is invalid.
5122	**The prescriber denial clarification field on the input claim was invalid. Valid values are '0' thru '07'.**	**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.
5124	**Multiple national miscellaneous procedure codes not allowed on one claim.**	**125**	Submission-billing error(s)	**N61**	Rebill services on separate claims.	**454**	Procedure code for services rendered.
5125	**SRN Missing-invalid.**	**15**	The authorization number is missing, invalid, or does not apply to the billed services or provider	**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.
5126	**National miscellaneous code or submitted SRN invalid.**	**15**	The authorization number is missing, invalid, or does not apply to the billed services or provider	**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.
5127	**Procedure code not allowed after March 1, 2004.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N302**	Missing-incomplete-invalid other procedure date(s).	**454**	Procedure code for services rendered.
5128	**National miscellaneous codes cannot be billed prior to March 1, 2004.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N302**	Missing-incomplete-invalid other procedure date(s).	**454**	Procedure code for services rendered.

5129	**Provider number on claim does nots match provider number on record; contact HP at 1-800-688-6696**	**125**	Submission-billing error(s)	**N521**	Mismatch between the submitted provider information and the provider information stored in our system.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
5130	**Procedure code billed does not match procedure code on record; contact CCME 1-800-228-3365**	**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.
5130	**Procedure code billed does not match procedure code on record; contact CCME 1-800-228-3365**	**125**	Submission-billing error(s)	**N188**	The approved level of care does not match the procedure code submitted.	**465**	Principal Procedure Code for Service(s) Rendered
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.
5201	**Diagnosis procedure allowed once-day unless billed with appro modifier,.**	**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.
5202	**Repeat diagnostic procedure allowed twice - 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.
5202	**Repeat diagnostic procedure allowed twice - day.**	**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-	**259**	Frequency of service.
					between this service-procedure-		

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).
5205	**PROCEDURE-SERVICE CANNOT BE VERIFIED AS BEING PERFORMED FOLLOWING REVIEW OF MEDICAL RECORD/OPERATING NOTE PROVIDED**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-incomplete-invalid documentation-orders-notes-summary-report-chart.	**123**	Additional information requested from entity.
5205	**PROCEDURE-SERVICE CANNOT BE VERIFIED AS BEING PERFORMED FOLLOWING REVIEW OF MEDICAL RECORD/OPERATING NOTE PROVIDED**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-incomplete-invalid documentation-orders-notes-summary-report-chart.	**297**	Medical notes/report.
5206	**Multiple details with modifier 55 appended must have the same date of service. Please correct 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.
5211	**Modifier cc is for internal use only: to be applied only by the payer. Remove modifier cc and resubmit either as a new day claim or an adjustment.**	**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.

5216	**Billing of procedures w modifier 55 and different post op periods is not allowed on the same claim.**	**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.	**N61**	Rebill services on separate claims.	**258**	Days-units for procedure-revenue code.
5221	**No payment for add-on (size) code allowed if primary code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
5221	**No payment for add-on (size) code allowed if primary code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
5222	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
5222	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.

5223	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
5223	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
5224	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
5224	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
5225	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
5225	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.

5226	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
5226	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
5227	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
5227	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
5228	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
5228	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.

5229	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
5229	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
5230	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
5230	**No payment for add-on (size) code allowed if 'primary' code in series is not paid for the same DOS, same provider.**	**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.	**454**	Procedure code for services rendered.
5231	**Only one surgical code per day is allowed as the primary procedure. Another code has already been billed a primary for this DOS.**	**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.
5231	**Only one surgical code per day is allowed as the primary procedure. Another code has already been billed a primary for this DOS.**	**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

5232	**Only one surgical code per day is allowed as the primary procedure. Another code has already been billed a primary for this DOS. Correct detail by appending -51 and rebill.**	**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.
5232	**Only one surgical code per day is allowed as the primary procedure. Another code has already been billed a primary for this DOS. Correct detail by appending -51 and rebill.**	**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
5233	**Only one surgical code per day is allowed as the primary procedure. Another code has already been billed a primary for this DOS. Correct detail by appending -51 and rebill.**	**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.
5234	**Procedure is included in open cholecystectomy.**	**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.
5238	**Service included in OB package.**	**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.
5239	**Units cutback. Exceeds maximum units allowed- 60 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.

5240	**Service included in the OB pkg.**	**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.
5241	**OB pkg code has been billed. Previously billed related service are not allowed.**	**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.
5242	**Service included in the OB pkg.**	**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.
5243	**OB pkg code has been billed. Previously billed related service are not allowed.**	**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.
5308	**Prior authorized units exceeded.**	**198**	Precertification-authorization exceeded	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**48**	Referral-authorization.

5311	**PRIOR APPROVAL REQUIRED. PROVIDER GO TO WWW.SMARTDUR.COM OR CALL 919.855.4300**	**197**	Precertification-authorization-notification absent.	**N54**	Claim information is inconsistent with pre-certified-authorized services.	**25**	Entity not approved.
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.
5327	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5327	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER DAY**	**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.
5327	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5327	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER DAY**	**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.
5327	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount

5327	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER DAY**	**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	**612**	Per Day Limit Amount
5328	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5328	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER MONTH**	**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.
5328	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5328	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER MONTH**	**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.
5329	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER 60 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.
5329	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER 60 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.
5329	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER 60 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.
5329	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER 60 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.
5330	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-225 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.

5330	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-225 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.
5330	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-225 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.
5330	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-225 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.
5331	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-270 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.
5331	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-270 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.
5331	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-270 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.
5331	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-270 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.
5332	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5332	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5332	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5332	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.

5332	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5332	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5333	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5333	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-MONTH**	**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.
5333	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5333	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-MONTH**	**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.
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.
5335	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5335	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.

5335	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5335	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5335	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5335	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5336	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED -3 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.
5336	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED -3 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.
5336	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED -3 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.
5336	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED -3 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.
5337	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5337	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5337	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5337	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.

5337	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5337	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5338	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5338	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5338	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5338	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5338	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5338	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5339	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5339	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5339	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5339	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.

5339	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5339	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5340	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5340	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5340	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5340	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5340	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5340	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5341	**UNITS CUTBACK. EXCEES MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5341	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5341	**UNITS CUTBACK. EXCEES MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5341	**UNITS CUTBACK. EXCEES MAXIMUM UNITS ALLOWED-DAY**	**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.

5341	**UNITS CUTBACK. EXCEES MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5341	**UNITS CUTBACK. EXCEES MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5342	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5342	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5342	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5342	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5342	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5342	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5343	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5343	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5343	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5343	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.

5343	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5343	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5344	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5344	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5344	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5344	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5344	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5344	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5345	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5345	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5345	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5345	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.

5345	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5345	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5346	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5346	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5346	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5346	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5346	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5346	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5347	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5347	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5347	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5347	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.

5347	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5347	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5348	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5348	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5348	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5348	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5348	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5348	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5349	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5349	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5349	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5349	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.

5349	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5349	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5350	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5350	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5350	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5350	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5350	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5350	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5351	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5351	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5351	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5351	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.

5351	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5351	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5352	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5352	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5352	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5352	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5352	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5352	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5353	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5353	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5353	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5353	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.

5353	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5353	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5354	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5354	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5354	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5354	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5354	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5354	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5355	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5355	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.
5355	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5355	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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.

5355	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5355	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-DAY**	**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	**612**	Per Day Limit Amount
5356	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED- 6 MONTHS**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N411**	This service is allowed one time in a 6-month period.	**259**	Frequency of service.
5357	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED- 14 DAYS**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5357	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED- 14 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.
5357	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED- 14 DAYS**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5357	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED- 14 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.
5358	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED- 30 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.
5358	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED- 30 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.
5358	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED- 30 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.
5358	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED- 30 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.

5359	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-80 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.
5359	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-80 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.
5359	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-80 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.
5359	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-80 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.
5360	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER CALENDAR QUARTER**	**119**	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.
5360	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER CALENDAR QUARTER**	**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.
5360	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER CALENDAR QUARTER**	**119**	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.
5360	**UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED PER CALENDAR QUARTER**	**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.
5363	**UNITS CUTBACK. EXCEEDS THE MAXIUM 100 MEDICAID UNITS ALLOWED PER 84 DAY 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.	**258**	Days-units for procedure-revenue code.
5363	**UNITS CUTBACK. EXCEEDS THE MAXIUM 100 MEDICAID UNITS ALLOWED PER 84 DAY LIMITATION**	**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.

5363	**UNITS CUTBACK. EXCEEDS THE MAXIUM 100 MEDICAID UNITS ALLOWED PER 84 DAY 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.
5363	**UNITS CUTBACK. EXCEEDS THE MAXIUM 100 MEDICAID UNITS ALLOWED PER 84 DAY LIMITATION**	**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.
5364	**UNITS CUTBACK. EXCEEDS THE MAXIUM 600 UNITS ALLOWED PER 90 DAY 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.	**258**	Days-units for procedure-revenue code.
5364	**UNITS CUTBACK. EXCEEDS THE MAXIUM 600 UNITS ALLOWED PER 90 DAY LIMITATION**	**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.
5364	**UNITS CUTBACK. EXCEEDS THE MAXIUM 600 UNITS ALLOWED PER 90 DAY 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.
5364	**UNITS CUTBACK. EXCEEDS THE MAXIUM 600 UNITS ALLOWED PER 90 DAY LIMITATION**	**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.
5365	**PROCEDURE CODE COVERS BOTH AXILLAE. UNITS CUTBACK TO THE ALLOWABLE ONE UNIT PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**476**	Missing or invalid units of service.
5365	**PROCEDURE CODE COVERS BOTH AXILLAE. UNITS CUTBACK TO THE ALLOWABLE ONE UNIT PER DAY**	**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	**476**	Missing or invalid units of service.
5365	**PROCEDURE CODE COVERS BOTH AXILLAE. UNITS CUTBACK TO THE ALLOWABLE ONE UNIT PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount

5365	**PROCEDURE CODE COVERS BOTH AXILLAE. UNITS CUTBACK TO THE ALLOWABLE ONE UNIT PER DAY**	**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	**612**	Per Day Limit Amount
5377	**DME INCONTINENCE SUPPLY LIMITED TO 192 UNITS PER CALENDAR MONTH, SAME OR DIFFERENT PROVIDER**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Freqency of service.
	DME INCONTINENCE SUPPLY LIMITED TO 200 UNITS PER CALENDAR MONTH, SAME OR DIFFERENT PROVIDER	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Freqency of service.
5400	**EXACT DUP, SAME ATTD PROV-PCODE-TOS-DOS-MOD-DTL ##-DIFF ICN**	**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.
5400	**EXACT DUP, SAME ATTD PROV-PCODE-TOS-DOS-MOD-DTL ##-DIFF ICN**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**250**	Type of Service.
5401	**DUP, SAME ATTD PROV- pcode-TOS-DOS-RELATED MOD**	**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.
5401	**DUP, SAME ATTD PROV- pcode-TOS-DOS-RELATED MOD**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**250**	Type of Service.
5402	**DUPLICATE: SAME ATTD PROV-PCODE-TOS-DOS-RELATED MODIFIER**	**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.
5402	**DUPLICATE: SAME ATTD PROV-PCODE-TOS-DOS-RELATED MODIFIER**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**250**	Type of Service.
5403	**DUPLICATE: SAME ATTD PROV-PCODE-TOS-DOS-RELATED MODIFER**	**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.

5403	**DUPLICATE: SAME ATTD PROV-PCODE-TOS-DOS-RELATED MODIFER**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**250**	Type of Service.
5404	**DUPLICATE: SAME ATTD PROV-PCODE-TOS-DOS-MODIFIER**	**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.
5404	**DUPLICATE: SAME ATTD PROV-PCODE-TOS-DOS-MODIFIER**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**250**	Type of Service.
5405	**EXACT DUP, SAME ATTD PROV-PCODE-TOS-DOS-MOD-DTL ##-ICN**	**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.
5405	**EXACT DUP, SAME ATTD PROV-PCODE-TOS-DOS-MOD-DTL ##-ICN**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**250**	Type of Service.
5406	**Duplicate. Same procedure-Modifiers not allwed for same day, same or different providers**	**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.
5407	**SEVERE DUP, SAME ATTD PROV-PCODE-TOS-DOS-MOD**	**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.
5407	**SEVERE DUP, SAME ATTD PROV-PCODE-TOS-DOS-MOD**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**250**	Type of Service.
5408	**Suspect dup, same billing prov-pcode- TOS- DOS-DTL ## - TOT pricing verses modifier pricing.**	**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.
5409	**SUSPECT DUP-SAME ATTD PROV-PCODE-TOS-DOS-TOT PROCESSING VERSUS MODIFIER PROCESSING**	**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.

5409	**SUSPECT DUP-SAME ATTD PROV-PCODE-TOS-DOS-TOT PROCESSING VERSUS MODIFIER PROCESSING**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**250**	Type of Service.
5410	**DUP, SAME PCODE-TOS-MOD-DOS-ICN**	**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.
5410	**DUP, SAME PCODE-TOS-MOD-DOS-ICN**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**250**	Type of Service.
5500	**FOLLOW-UP CARE IS INCLUDED IN GLOBAL SURGERY PACKAGE**	**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.
5521	**FOLLOW-UP CARE IS INCLUDED IN GLOBAL SURGERY PACKAGE**	**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.
5428	**Immunization administration or therapeutic injection recouped, not allowed with E/M on same date of service, same billing provider**	**169**	Alternate benefit has been provided.	**N20**	**Service not payable with other service rendered on the same date.**	**453**	**Procedure Code Modifier(s) for Service(s) Rendered**
5553	**SERVICE DENIED. DRUG LIMITED TO 228 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.

5553	**SERVICE DENIED. DRUG LIMITED TO 228 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5553	**SERVICE DENIED. DRUG LIMITED TO 228 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
5553	**SERVICE DENIED. DRUG LIMITED TO 228 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5553	**SERVICE DENIED. DRUG LIMITED TO 228 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
5553	**SERVICE DENIED. DRUG LIMITED TO 228 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**585**	Denied Charge or Non-covered Charge
5554	**SERVICE DENIED. DRUG LIMITED TO 50 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
5554	**SERVICE DENIED. DRUG LIMITED TO 50 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5554	**SERVICE DENIED. DRUG LIMITED TO 50 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
5554	**SERVICE DENIED. DRUG LIMITED TO 50 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5554	**SERVICE DENIED. DRUG LIMITED TO 50 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
5554	**SERVICE DENIED. DRUG LIMITED TO 50 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**585**	Denied Charge or Non-covered Charge
5555	**SERVICE DENIED. DRUG LIMITED TO 300 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.

5555	**SERVICE DENIED. DRUG LIMITED TO 300 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5555	**SERVICE DENIED. DRUG LIMITED TO 300 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
5555	**SERVICE DENIED. DRUG LIMITED TO 300 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5555	**SERVICE DENIED. DRUG LIMITED TO 300 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
5555	**SERVICE DENIED. DRUG LIMITED TO 300 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**585**	Denied Charge or Non-covered Charge
5556	**SERVICE DENIED. DRUG LIMITED TO 3000 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
5556	**SERVICE DENIED. DRUG LIMITED TO 3000 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
5556	**SERVICE DENIED. DRUG LIMITED TO 3000 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
5556	**SERVICE DENIED. DRUG LIMITED TO 3000 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5556	**SERVICE DENIED. DRUG LIMITED TO 3000 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
5556	**SERVICE DENIED. DRUG LIMITED TO 3000 UNITS PER CALENDAR MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**585**	Denied Charge or Non-covered Charge
5557	**CSHS exceeds limitation of $2000.00 per calendar month, same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.

5558	**This provider is not authorized by DMA to receive reimbursement for the procedure code billed**	**170**	Payment is denied when performed-billed by this type of provider. 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.	**N95**	This provider type-provider specialty may not bill this service.	**91**	Entity not eligible-not approved for dates of service. Note- This code requires use of an Entity Code.
5560	**Supply of injectable contrast material requires appropriate procedure on the 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.	**N19**	Procedure code incidental to primary procedure.	**258**	Days-units for procedure-revenue code.
5563	**DRUG LIMITED TO 228 UNITS PER CALENDAR MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5563	**DRUG LIMITED TO 228 UNITS PER CALENDAR MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**119**	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.
5563	**DRUG LIMITED TO 228 UNITS PER CALENDAR MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5563	**DRUG LIMITED TO 228 UNITS PER CALENDAR MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**119**	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.
5564	**DRUG LIMITED TO 50 UNITS PER CALENDAR MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.

5564	**DRUG LIMITED TO 50 UNITS PER CALENDAR MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**119**	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.
5564	**DRUG LIMITED TO 50 UNITS PER CALENDAR MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5564	**DRUG LIMITED TO 50 UNITS PER CALENDAR MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**119**	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.
5565	**DRUG LIMITED TO 300 UNITS PER CALENDAR MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5565	**DRUG LIMITED TO 300 UNITS PER CALENDAR MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**119**	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.
5565	**DRUG LIMITED TO 300 UNITS PER CALENDAR MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5565	**DRUG LIMITED TO 300 UNITS PER CALENDAR MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**119**	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.
5566	**DRUG LIMITED TO 3000 UNITS PER CALENDAR MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5566	**DRUG LIMITED TO 3000 UNITS PER CALENDAR MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**119**	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.
5566	**DRUG LIMITED TO 3000 UNITS PER CALENDAR MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.

5566	**DRUG LIMITED TO 3000 UNITS PER CALENDAR MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**119**	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.
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.
5700	**RELATED ENDOSCOPY PROCEDURE MUST BE BILLED WITH PRIMARY PROCEDURE**	**A1**	Claim-Service denied	**M51**	Missing-incomplete-invalid procedure code(s).	**454**	Procedure code for services rendered.
5700	**RELATED ENDOSCOPY PROCEDURE MUST BE BILLED WITH PRIMARY PROCEDURE**	**A1**	Claim-Service denied	**M51**	Missing-incomplete-invalid procedure code(s).	**490**	Other Procedure Code for Service(s) Rendered.
5701	**RELATED LAPAROSCOPY CODES NOT ALLOWED ON SAME DAY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5701	**RELATED LAPAROSCOPY CODES NOT ALLOWED ON SAME DAY**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.

5701	**RELATED LAPAROSCOPY CODES NOT ALLOWED ON SAME DAY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5701	**RELATED LAPAROSCOPY CODES NOT ALLOWED ON SAME DAY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5701	**RELATED LAPAROSCOPY CODES NOT ALLOWED ON SAME DAY**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
5701	**RELATED LAPAROSCOPY CODES NOT ALLOWED ON SAME DAY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5702	**RELATED SURGICAL PROCEDURE HAS PREVIOUSLY PAID FOR THIS DOS**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**454**	Procedure code for services rendered.
5702	**RELATED SURGICAL PROCEDURE HAS PREVIOUSLY PAID FOR THIS DOS**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5702	**RELATED SURGICAL PROCEDURE HAS PREVIOUSLY PAID FOR THIS DOS**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**M15**	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	**666**	Surgical Procedure Code.
5702	**RELATED SURGICAL PROCEDURE HAS PREVIOUSLY PAID FOR THIS DOS**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**N20**	Service not payable with other service rendered on the same date.	**666**	Surgical Procedure Code.
5703	**RELATED BIOPSY INCISION PROCEDURES NOT ON SAME DAY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

5703	**RELATED BIOPSY INCISION PROCEDURES NOT ON SAME DAY**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
5703	**RELATED BIOPSY INCISION PROCEDURES NOT ON SAME DAY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5703	**RELATED BIOPSY INCISION PROCEDURES NOT ON SAME DAY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5703	**RELATED BIOPSY INCISION PROCEDURES NOT ON SAME DAY**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
5703	**RELATED BIOPSY INCISION PROCEDURES NOT ON SAME DAY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5704	**SERVICE RECOUPED. RELATED BIOPSY INCISION PROCEDURES NOT ON SAME DAY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5704	**SERVICE RECOUPED. RELATED BIOPSY INCISION PROCEDURES NOT ON SAME DAY**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
5704	**SERVICE RECOUPED. RELATED BIOPSY INCISION PROCEDURES NOT ON SAME DAY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5704	**SERVICE RECOUPED. RELATED BIOPSY INCISION PROCEDURES NOT ON SAME DAY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5704	**SERVICE RECOUPED. RELATED BIOPSY INCISION PROCEDURES NOT ON SAME DAY**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.

5704	**SERVICE RECOUPED. RELATED BIOPSY INCISION PROCEDURES NOT ON SAME DAY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5705	**RELATED SURGICAL PROCEDURES NOT ALLOWED SAME DAY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5705	**RELATED SURGICAL PROCEDURES NOT ALLOWED SAME DAY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5705	**RELATED SURGICAL PROCEDURES NOT ALLOWED SAME DAY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5705	**RELATED SURGICAL PROCEDURES NOT ALLOWED SAME DAY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5706	**ARTHROPLASTY PROCEDURE NOT ALLOWED SAME DAY AS MICROSURGERY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5706	**ARTHROPLASTY PROCEDURE NOT ALLOWED SAME DAY AS MICROSURGERY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5706	**ARTHROPLASTY PROCEDURE NOT ALLOWED SAME DAY AS MICROSURGERY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5706	**ARTHROPLASTY PROCEDURE NOT ALLOWED SAME DAY AS MICROSURGERY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5707	**RELATED AUTOGRAFT PROCEDURES BOT ALLOWED SAME DAY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

5707	**RELATED AUTOGRAFT PROCEDURES BOT ALLOWED SAME DAY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5707	**RELATED AUTOGRAFT PROCEDURES BOT ALLOWED SAME DAY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5707	**RELATED AUTOGRAFT PROCEDURES BOT ALLOWED SAME DAY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5708	**AUTOGRAFT NOT ALLOWED SAME DAY AS ARTHROSCOPY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5708	**AUTOGRAFT NOT ALLOWED SAME DAY AS ARTHROSCOPY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5708	**AUTOGRAFT NOT ALLOWED SAME DAY AS ARTHROSCOPY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5708	**AUTOGRAFT NOT ALLOWED SAME DAY AS ARTHROSCOPY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5709	**ARTHROSCOPY NOT ALLOWED SAME DAY AS AUTOGRAFT**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5709	**ARTHROSCOPY NOT ALLOWED SAME DAY AS AUTOGRAFT**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5709	**ARTHROSCOPY NOT ALLOWED SAME DAY AS AUTOGRAFT**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5709	**ARTHROSCOPY NOT ALLOWED SAME DAY AS AUTOGRAFT**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.

5710	**ARTHROSCOPY NOT ALLOWED SAME DAY AS RELATED PROCEDURE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5710	**ARTHROSCOPY NOT ALLOWED SAME DAY AS RELATED PROCEDURE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5710	**ARTHROSCOPY NOT ALLOWED SAME DAY AS RELATED PROCEDURE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5710	**ARTHROSCOPY NOT ALLOWED SAME DAY AS RELATED PROCEDURE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5711	**RELATED PROCEDURE NOT ALLOWED SAME DAY AS ARTHROSCOPY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5711	**RELATED PROCEDURE NOT ALLOWED SAME DAY AS ARTHROSCOPY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5711	**RELATED PROCEDURE NOT ALLOWED SAME DAY AS ARTHROSCOPY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5711	**RELATED PROCEDURE NOT ALLOWED SAME DAY AS ARTHROSCOPY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5712	**BYPASS GRAFT PROCEDURE NOT ALLOWED SAME DAY AS RELATED VEIN PROCEDURE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5712	**BYPASS GRAFT PROCEDURE NOT ALLOWED SAME DAY AS RELATED VEIN PROCEDURE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.

5712	**BYPASS GRAFT PROCEDURE NOT ALLOWED SAME DAY AS RELATED VEIN PROCEDURE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5712	**BYPASS GRAFT PROCEDURE NOT ALLOWED SAME DAY AS RELATED VEIN PROCEDURE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5713	**RELATED VEIN PROCEDURE NOT ALLOWED SAME DAY AS BYPASS GRAFT**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5713	**RELATED VEIN PROCEDURE NOT ALLOWED SAME DAY AS BYPASS GRAFT**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5713	**RELATED VEIN PROCEDURE NOT ALLOWED SAME DAY AS BYPASS GRAFT**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5713	**RELATED VEIN PROCEDURE NOT ALLOWED SAME DAY AS BYPASS GRAFT**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5714	**BYPASS GRAFT OF VEIN NOT ALLOWED SAME DAY AS REPAIR PROCEDURE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5714	**BYPASS GRAFT OF VEIN NOT ALLOWED SAME DAY AS REPAIR PROCEDURE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5714	**BYPASS GRAFT OF VEIN NOT ALLOWED SAME DAY AS REPAIR PROCEDURE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.

5714	**BYPASS GRAFT OF VEIN NOT ALLOWED SAME DAY AS REPAIR PROCEDURE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5715	**REPAIR PROCEDURE OF VEIN NOT ALLOWED SAME DAY AS BYPASS GRAFT**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5715	**REPAIR PROCEDURE OF VEIN NOT ALLOWED SAME DAY AS BYPASS GRAFT**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5715	**REPAIR PROCEDURE OF VEIN NOT ALLOWED SAME DAY AS BYPASS GRAFT**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5715	**REPAIR PROCEDURE OF VEIN NOT ALLOWED SAME DAY AS BYPASS GRAFT**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5716	**BYPASS GRAFT NOT ALLOWED SAME DAY AS RELATED SURGICAL PROCEDURE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5716	**BYPASS GRAFT NOT ALLOWED SAME DAY AS RELATED SURGICAL PROCEDURE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5716	**BYPASS GRAFT NOT ALLOWED SAME DAY AS RELATED SURGICAL PROCEDURE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5716	**BYPASS GRAFT NOT ALLOWED SAME DAY AS RELATED SURGICAL PROCEDURE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.

5717	**RELATED SURGICAL PROCEDURE NOT ALLOWED SAME DAY AS BYPASS PROCEDURE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5717	**RELATED SURGICAL PROCEDURE NOT ALLOWED SAME DAY AS BYPASS PROCEDURE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5717	**RELATED SURGICAL PROCEDURE NOT ALLOWED SAME DAY AS BYPASS PROCEDURE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5717	**RELATED SURGICAL PROCEDURE NOT ALLOWED SAME DAY AS BYPASS PROCEDURE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5718	**PROGRAMMING DEVICE EVALUATION NOT ALLOWED SAME DAY AS PERI-PROCEDURAL DEVICE EVALUATION**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5718	**PROGRAMMING DEVICE EVALUATION NOT ALLOWED SAME DAY AS PERI-PROCEDURAL DEVICE EVALUATION**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5718	**PROGRAMMING DEVICE EVALUATION NOT ALLOWED SAME DAY AS PERI-PROCEDURAL DEVICE EVALUATION**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5718	**PROGRAMMING DEVICE EVALUATION NOT ALLOWED SAME DAY AS PERI-PROCEDURAL DEVICE EVALUATION**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5719	**PERI-PROCEDURAL DEVICE EVALUATION NOT ALLOWED SAME DAY AS PROGRAMMING DEVICE EVALUATION**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

5719	**PERI-PROCEDURAL DEVICE EVALUATION NOT ALLOWED SAME DAY AS PROGRAMMING DEVICE EVALUATION**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5719	**PERI-PROCEDURAL DEVICE EVALUATION NOT ALLOWED SAME DAY AS PROGRAMMING DEVICE EVALUATION**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5719	**PERI-PROCEDURAL DEVICE EVALUATION NOT ALLOWED SAME DAY AS PROGRAMMING DEVICE EVALUATION**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5720	**CARDIOGRAPHY PROCEDURE NOT ALLOWED SAME DAY AS CARDIOVASCULAR DEVICE MONITORING**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5720	**CARDIOGRAPHY PROCEDURE NOT ALLOWED SAME DAY AS CARDIOVASCULAR DEVICE MONITORING**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5720	**CARDIOGRAPHY PROCEDURE NOT ALLOWED SAME DAY AS CARDIOVASCULAR DEVICE MONITORING**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5720	**CARDIOGRAPHY PROCEDURE NOT ALLOWED SAME DAY AS CARDIOVASCULAR DEVICE MONITORING**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5721	**CARDIOVASCULAR DEVICE MONITORING NOT ALLOWED SAME DAY AS CARDIPGRAPHY PROCEDURE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

5721	**CARDIOVASCULAR DEVICE MONITORING NOT ALLOWED SAME DAY AS CARDIPGRAPHY PROCEDURE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5721	**CARDIOVASCULAR DEVICE MONITORING NOT ALLOWED SAME DAY AS CARDIPGRAPHY PROCEDURE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5721	**CARDIOVASCULAR DEVICE MONITORING NOT ALLOWED SAME DAY AS CARDIPGRAPHY PROCEDURE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5722	**RELATED CARDIOGRAPHY EVALUATION NOT ALLOWED ON SAME DAY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5722	**RELATED CARDIOGRAPHY EVALUATION NOT ALLOWED ON SAME DAY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5722	**RELATED CARDIOGRAPHY EVALUATION NOT ALLOWED ON SAME DAY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5722	**RELATED CARDIOGRAPHY EVALUATION NOT ALLOWED ON SAME DAY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5723	**RELATED IMPLANTABLE DEVICES NOT ALLOWED ON SAME DAY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5723	**RELATED IMPLANTABLE DEVICES NOT ALLOWED ON SAME DAY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.

5723	**RELATED IMPLANTABLE DEVICES NOT ALLOWED ON SAME DAY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5723	**RELATED IMPLANTABLE DEVICES NOT ALLOWED ON SAME DAY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5724	**RELATED PROCEDURE NOT ALLOWED SAME DAY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5724	**RELATED PROCEDURE NOT ALLOWED SAME DAY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5724	**RELATED PROCEDURE NOT ALLOWED SAME DAY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5724	**RELATED PROCEDURE NOT ALLOWED SAME DAY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.

5725	**DEVICE EVALUATION LIMITED TO ONCE PER 90 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.
5725	**DEVICE EVALUATION LIMITED TO ONCE PER 90 DAYS**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5725	**DEVICE EVALUATION LIMITED TO ONCE PER 90 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.	**612**	Per Day Limit Amount
5725	**DEVICE EVALUATION LIMITED TO ONCE PER 90 DAYS**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5726	**DEVICE EVALUATION LIMITED TO ONE 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.
5726	**DEVICE EVALUATION LIMITED TO ONE PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5726	**DEVICE EVALUATION LIMITED TO ONE 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
5726	**DEVICE EVALUATION LIMITED TO ONE PER DAY**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5727	**RELATED ECHOCARDIOGRAPH PROCEDURE REQUIRES PRIMARY 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.	**MA66**	Missing-incomplete-invalid principal procedure code.	**465**	Principal Procedure Code for Service(s) Rendered

5727	**RELATED ECHOCARDIOGRAPH PROCEDURE REQUIRES PRIMARY 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.	**M51**	Missing-incomplete-invalid procedure code(s).	**465**	Principal Procedure Code for Service(s) Rendered
5728	**ALLOGRAFT NOT ALLOWED SAME DAY AS RELATED ARTHROSCOPY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5728	**ALLOGRAFT NOT ALLOWED SAME DAY AS RELATED ARTHROSCOPY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5728	**ALLOGRAFT NOT ALLOWED SAME DAY AS RELATED ARTHROSCOPY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5728	**ALLOGRAFT NOT ALLOWED SAME DAY AS RELATED ARTHROSCOPY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5729	**RELATED ARTHROSCOPY NOT ALLOWED SAME DAY AS ALLOGRAFT**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5729	**RELATED ARTHROSCOPY NOT ALLOWED SAME DAY AS ALLOGRAFT**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5729	**RELATED ARTHROSCOPY NOT ALLOWED SAME DAY AS ALLOGRAFT**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.

5729	**RELATED ARTHROSCOPY NOT ALLOWED SAME DAY AS ALLOGRAFT**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5730	**Technical component of evaluation already paid within 90 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.	**483**	Maximum coverage amount met or exceeded for benefit period.
5731	**Professional component of evaluation already paid within 90 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.	**483**	Maximum coverage amount met or exceeded for benefit period.
5858	**E&M ALREADY PAID FOR THIS DATE OF SERVICE BY SAME ATTENDING PROVIDER. FILE ADJUSTMENT WITH MEDICAL DOCUMENTATION TO SUPPORT MEDICAL NECESSITY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5858	**E&M ALREADY PAID FOR THIS DATE OF SERVICE BY SAME ATTENDING PROVIDER. FILE ADJUSTMENT WITH MEDICAL DOCUMENTATION TO SUPPORT MEDICAL NECESSITY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5858	**E&M ALREADY PAID FOR THIS DATE OF SERVICE BY SAME ATTENDING PROVIDER. FILE ADJUSTMENT WITH MEDICAL DOCUMENTATION TO SUPPORT MEDICAL NECESSITY**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**287**	Medical necessity for service.

5858	**E&M ALREADY PAID FOR THIS DATE OF SERVICE BY SAME ATTENDING PROVIDER. FILE ADJUSTMENT WITH MEDICAL DOCUMENTATION TO SUPPORT MEDICAL NECESSITY**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**287**	Medical necessity for service.
5859	**RECOUP E&M, NOT ALLOWED SAME DAY AS NORMAL NEWBORN CARE RECEIVED BY A DIFFERENT ATTENDING PROVIDER**	**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.	**187**	Date(s) of service.
5859	**RECOUP E&M, NOT ALLOWED SAME DAY AS NORMAL NEWBORN CARE RECEIVED BY A DIFFERENT ATTENDING PROVIDER**	**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.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5859	**RECOUP E&M, NOT ALLOWED SAME DAY AS NORMAL NEWBORN CARE RECEIVED BY A DIFFERENT ATTENDING PROVIDER**	**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.	**259**	Date(s) of service.

5859	**RECOUP E&M, NOT ALLOWED SAME DAY AS NORMAL NEWBORN CARE RECEIVED BY A DIFFERENT ATTENDING PROVIDER**	**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.	**N20**	Service not payable with other service rendered on the same date.	**259**	Date(s) of service.
5860	**ONLY ONE NEONATAL OR PEDIATRIC INITIAL DAY CRITICAL CARE SERVICE ALLOWED WITHIN A 10 DAY PERIOD PER HOSPITALIZATION**	**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**	Date(s) of service.
5860	**ONLY ONE NEONATAL OR PEDIATRIC INITIAL DAY CRITICAL CARE SERVICE ALLOWED WITHIN A 10 DAY PERIOD PER HOSPITALIZATION**	**119**	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**	Date(s) of service.
5860	**ONLY ONE NEONATAL OR PEDIATRIC INITIAL DAY CRITICAL CARE SERVICE ALLOWED WITHIN A 10 DAY PERIOD PER HOSPITALIZATION**	**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.
5860	**ONLY ONE NEONATAL OR PEDIATRIC INITIAL DAY CRITICAL CARE SERVICE ALLOWED WITHIN A 10 DAY PERIOD PER HOSPITALIZATION**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount.

5861	**DAILY CARE AND NORMAL NEWBORN CARE SAME ATTENDING SPECIALTY NOT PAID SAME DATE OF SERVICE**	**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.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
5861	**DAILY CARE AND NORMAL NEWBORN CARE SAME ATTENDING SPECIALTY NOT PAID SAME DATE OF SERVICE**	**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.	**259**	Frequency of service.
5862	**RECOUP DAILY CARE, NOT PAID SAME DATE OF SERVICE AS NORMAL NEWBORN CARE SAME ATTENDING SPECIALTY**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5862	**RECOUP DAILY CARE, NOT PAID SAME DATE OF SERVICE AS NORMAL NEWBORN CARE SAME ATTENDING SPECIALTY**	**169**	Alternate benefit has been provided.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
5862	**RECOUP DAILY CARE, NOT PAID SAME DATE OF SERVICE AS NORMAL NEWBORN CARE SAME ATTENDING SPECIALTY**	**169**	Alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5862	**RECOUP DAILY CARE, NOT PAID SAME DATE OF SERVICE AS NORMAL NEWBORN CARE SAME ATTENDING SPECIALTY**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.

5862	**RECOUP DAILY CARE, NOT PAID SAME DATE OF SERVICE AS NORMAL NEWBORN CARE SAME ATTENDING SPECIALTY**	**169**	Alternate benefit has been provided.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
5862	**RECOUP DAILY CARE, NOT PAID SAME DATE OF SERVICE AS NORMAL NEWBORN CARE SAME ATTENDING SPECIALTY**	**169**	Alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5863	**INPATIENT CONSULT AND NORMAL NEWBORN CARE SAME ATTENDING SPECIALTY NOT PADI SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**258**	Days-units for procedure-revenue code.
5863	**INPATIENT CONSULT AND NORMAL NEWBORN CARE SAME ATTENDING SPECIALTY NOT PADI SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
5864	**INPATIENT CONSULT RECOUPED, NOT PAID SAME DAY AS NORMAL NEWBORN CARE SAME ATTENDING SPECIALTY**	**169**	Alternate benefit has been provided.	**M80**	M80 - Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5864	**INPATIENT CONSULT RECOUPED, NOT PAID SAME DAY AS NORMAL NEWBORN CARE SAME ATTENDING SPECIALTY**	**169**	Alternate benefit has been provided.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
5864	**INPATIENT CONSULT RECOUPED, NOT PAID SAME DAY AS NORMAL NEWBORN CARE SAME ATTENDING SPECIALTY**	**169**	Alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5864	**INPATIENT CONSULT RECOUPED, NOT PAID SAME DAY AS NORMAL NEWBORN CARE SAME ATTENDING SPECIALTY**	**169**	Alternate benefit has been provided.	**M80**	M80 - Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.

5864	**INPATIENT CONSULT RECOUPED, NOT PAID SAME DAY AS NORMAL NEWBORN CARE SAME ATTENDING SPECIALTY**	**169**	Alternate benefit has been provided.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
5864	**INPATIENT CONSULT RECOUPED, NOT PAID SAME DAY AS NORMAL NEWBORN CARE SAME ATTENDING SPECIALTY**	**169**	Alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5865	**INITIAL NORMAL NEWBORN CARE NOT ALLOWED SAME DATE OF SERVICE AS NEONATAL OR PEDIATRIC CRITICAL CARE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**258**	Days-units for procedure-revenue code.
5865	**INITIAL NORMAL NEWBORN CARE NOT ALLOWED SAME DATE OF SERVICE AS NEONATAL OR PEDIATRIC CRITICAL CARE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
5866	**NEONATAL OR PEDIATRIC CRITICAL CARE SERVICES NOT ALLOWED SAME DATE OF SERVICE AS INITIAL NORNAL NEWBORN CARE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**258**	Days-units for procedure-revenue code.
5866	**NEONATAL OR PEDIATRIC CRITICAL CARE SERVICES NOT ALLOWED SAME DATE OF SERVICE AS INITIAL NORNAL NEWBORN CARE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
5867	**HOSPITAL CARE/DISCHARGE MANAGEMENT NOT ALLOWED SAME DAY AS INITIAL NORMAL NEWBORN CARE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**258**	Days-units for procedure-revenue code.

5867	**HOSPITAL CARE/DISCHARGE MANAGEMENT NOT ALLOWED SAME DAY AS INITIAL NORMAL NEWBORN CARE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
5868	**HOSPITAL CARE/DISCHARE MANAGEMENT RECOUPED, NOT ALLOWED SAME DAY AS INITIAL NORMAL NEWBORN CARE**	**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.	**M2**	Not paid separately when the patient is an inpatient.	**259**	Frequency of service.
5868	**HOSPITAL CARE/DISCHARE MANAGEMENT RECOUPED, NOT ALLOWED SAME DAY AS INITIAL NORMAL NEWBORN CARE**	**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.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
5868	**HOSPITAL CARE/DISCHARE MANAGEMENT RECOUPED, NOT ALLOWED SAME DAY AS INITIAL NORMAL NEWBORN CARE**	**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.	**259**	Frequency of service.

5869	**DAILY MANAGEMENT OR IMPATIENT CONSULT AND NEONATAL/PEDIATRIC CRITICAL CARE SERVICES SAME SPECIALTY NOT SAME DATE OF SERVICE**	**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.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
5869	**DAILY MANAGEMENT OR IMPATIENT CONSULT AND NEONATAL/PEDIATRIC CRITICAL CARE SERVICES SAME SPECIALTY NOT SAME DATE OF SERVICE**	**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.	**259**	Frequency of service.
5871	**ONLY ONE NEONATALOR PEDIATRIC CRITICAL CARE GLOBAL CODE IS ALLOWED PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
5871	**ONLY ONE NEONATALOR PEDIATRIC CRITICAL CARE GLOBAL CODE IS ALLOWED PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5871	**ONLY ONE NEONATALOR PEDIATRIC CRITICAL CARE GLOBAL CODE IS ALLOWED PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount.
5871	**ONLY ONE NEONATALOR PEDIATRIC CRITICAL CARE GLOBAL CODE IS ALLOWED PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount.

5872	**NEONATAL/PEDIATRIC CRITICAL CARE ADD ON CODE MUST BE BILLED WITH THE PRIMARY CRITICAL CARE 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.	**MA66**	Missing-incomplete-invalid principal procedure code.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
5872	**NEONATAL/PEDIATRIC CRITICAL CARE ADD ON CODE MUST BE BILLED WITH THE PRIMARY CRITICAL CARE 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).	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
5872	**NEONATAL/PEDIATRIC CRITICAL CARE ADD ON CODE MUST BE BILLED WITH THE PRIMARY CRITICAL CARE 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.	**N122**	Add-on code cannot be billed by itself.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

5872	**NEONATAL/PEDIATRIC CRITICAL CARE ADD ON CODE MUST BE BILLED WITH THE PRIMARY CRITICAL CARE 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.	**MA66**	Missing-incomplete-invalid principal procedure code.	**465**	Principal Procedure Code for Service(s) Rendered.
5872	**NEONATAL/PEDIATRIC CRITICAL CARE ADD ON CODE MUST BE BILLED WITH THE PRIMARY CRITICAL CARE 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.
5872	**NEONATAL/PEDIATRIC CRITICAL CARE ADD ON CODE MUST BE BILLED WITH THE PRIMARY CRITICAL CARE 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.	**N122**	Add-on code cannot be billed by itself.	**465**	Principal Procedure Code for Service(s) Rendered.
5873	**NEONATAL/PEDICATRIC CRITICAL CARE ADD-ON CODE UNITS EXCEED THE ALLOWABLE MAXIMUM OF 4 UNITS PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**483**	Maximum coverage amount met or exceeded for benefit period.

5873	**NEONATAL/PEDICATRIC CRITICAL CARE ADD-ON CODE UNITS EXCEED THE ALLOWABLE MAXIMUM OF 4 UNITS PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
5873	**NEONATAL/PEDICATRIC CRITICAL CARE ADD-ON CODE UNITS EXCEED THE ALLOWABLE MAXIMUM OF 4 UNITS PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
5873	**NEONATAL/PEDICATRIC CRITICAL CARE ADD-ON CODE UNITS EXCEED THE ALLOWABLE MAXIMUM OF 4 UNITS PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5874	**NEONATAL/PEDIATRIC CRITICAL CARE ADD-ON CODE**	**119**	Benefit maximum for this time period or occurrence has been	**M86**	Service denied because payment already made for	**483**	Maximum coverage amount met or exceeded for benefit
					between this service-procedure-		

5874	**NEONATAL/PEDIATRIC CRITICAL CARE ADD-ON CODE UNITS CUTBACK TO THE ALLOABLE 4 UNITS PER DATE OF SERVICE**	**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.	**612**	Per Day Limit Amount
5874	**NEONATAL/PEDIATRIC CRITICAL CARE ADD-ON CODE UNITS CUTBACK TO THE ALLOABLE 4 UNITS PER DATE OF SERVICE**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
5875	**RELATED DELIVERY AND BIRTHING CODES NOT ALLOWED ON THE SAME DATE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed	**187**	Date(s) of service.
					between this service-procedure-		

5876	**SERVICE DENIED. INCLUDE IN NEONATAL/PEDIATRIC CRITICAL CARE GLOBAL CODE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
5876	**SERVICE DENIED. INCLUDE IN NEONATAL/PEDIATRIC CRITICAL CARE GLOBAL CODE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
5877	**PROCEDURE RECOUPED, RENDERED SAME DAY AS NEONATAL CRITICAL CARE. COVERED IN PAYMENT OF NEONATAL CRITICAL CARE GLOBAL 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	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
					between this service-procedure-		

5877	**PROCEDURE RECOUPED, RENDERED SAME DAY AS NEONATAL CRITICAL CARE. COVERED IN PAYMENT OF NEONATAL CRITICAL CARE GLOBAL 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.
5877	**PROCEDURE RECOUPED, RENDERED SAME DAY AS NEONATAL CRITICAL CARE. COVERED IN PAYMENT OF NEONATAL CRITICAL CARE GLOBAL 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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5877	**PROCEDURE RECOUPED, RENDERED SAME DAY AS NEONATAL CRITICAL CARE. COVERED IN PAYMENT OF NEONATAL CRITICAL CARE GLOBAL 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.	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**454**	Procedure code for services rendered.
5878	**RELATED E/M CODE BILLED BY A DIFFERENT ATTENDING IS NOT ALLOWED ON THE SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5878	**RELATED E/M CODE BILLED BY A DIFFERENT ATTENDING IS NOT ALLOWED ON THE SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5878	**RELATED E/M CODE BILLED BY A DIFFERENT ATTENDING IS NOT ALLOWED ON THE SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.

5878	**RELATED E/M CODE BILLED BY A DIFFERENT ATTENDING IS NOT ALLOWED ON THE SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
5879	**MEDICAL DOCUMENTATION DOES NOT SUPPORT JUSTIFICATION FOR MULTIPLE VISITS SAME DATE OF SERVICE**	**50**	These are non-covered services because this is not deemed a `medical necessity by the payer.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5879	**MEDICAL DOCUMENTATION DOES NOT SUPPORT JUSTIFICATION FOR MULTIPLE VISITS SAME DATE OF SERVICE**	**50**	These are non-covered services because this is not deemed a `medical necessity by the payer.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5882	**NORMAL NEWBORN CARE NOT ALLOWED SAME DATE OF SERVICE AS INITIAL HOSPITAL CARE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**258**	Days-units for procedure-revenue code.
5882	**NORMAL NEWBORN CARE NOT ALLOWED SAME DATE OF SERVICE AS INITIAL HOSPITAL CARE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
5883	**INITIAL HOSPITAL CARE NOT ALLOWED SAME DATE OF SERVICE AS NORMAL NEWBORN CARE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**258**	Days-units for procedure-revenue code.
5883	**INITIAL HOSPITAL CARE NOT ALLOWED SAME DATE OF SERVICE AS NORMAL NEWBORN CARE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.

5884	**ONLY ONE NORMAL NEWBORN CARE OR PEDIATRIC CRITICAL CARE OR PEDICATRIC CRITICAL CARE SERVICE ALLOWED PER DATE OF SERVICE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**258**	Days-units for procedure-revenue code.
5884	**ONLY ONE NORMAL NEWBORN CARE OR PEDIATRIC CRITICAL CARE OR PEDICATRIC CRITICAL CARE SERVICE ALLOWED PER DATE OF SERVICE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
5885	**NORMAL NEWBORN CARE NOT ALLOWED SAME DAY AS NEONATAL CRITICAL CARE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**258**	Days-units for procedure-revenue code.
5885	**NORMAL NEWBORN CARE NOT ALLOWED SAME DAY AS NEONATAL CRITICAL CARE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
5886	**NORMAL NEWBORN CARE NOT ALLOWED SAME DAY AS HOSPITAL OF DISCHARGE MANAGEMENT**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**258**	Days-units for procedure-revenue code.
5886	**NORMAL NEWBORN CARE NOT ALLOWED SAME DAY AS HOSPITAL OF DISCHARGE MANAGEMENT**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.
5887	**HOSPITAL DISCHARGE MANAGEMENT NOT ALLOWED THE SAME DARE AS NORMAL NEWBORN CARE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**258**	Days-units for procedure-revenue code.
5887	**HOSPITAL DISCHARGE MANAGEMENT NOT ALLOWED THE SAME DARE AS NORMAL NEWBORN CARE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**258**	Days-units for procedure-revenue code.

5888	**REPOSTIONING PROCEDURE NOT ALLOWED SAME DAS AS RELATED PROCEDURE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5888	**REPOSTIONING PROCEDURE NOT ALLOWED SAME DAS AS RELATED PROCEDURE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5888	**REPOSTIONING PROCEDURE NOT ALLOWED SAME DAS AS RELATED PROCEDURE**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**187**	Date(s) of service.
5888	**REPOSTIONING PROCEDURE NOT ALLOWED SAME DAS AS RELATED PROCEDURE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
					between this service-procedure-		

5889	**RELATED PROCEDURES NOT ALLOWED SAME DAY AS REPOSTIONING PROCEDURE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5889	**RELATED PROCEDURES NOT ALLOWED SAME DAY AS REPOSTIONING PROCEDURE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5889	**RELATED PROCEDURES NOT ALLOWED SAME DAY AS REPOSTIONING PROCEDURE**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**454**	Procedure code for services rendered.
5890	**ALCOHOL/SUBSTANCE ABUSE SCREENING AND**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date	**187**	Date(s) of service.
					between this service-procedure-		

5891	**RELATED BEHAVIOR INTERVENTION COUNSELING CODES NOT ALLOWED ON THE SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5891	**RELATED BEHAVIOR INTERVENTION COUNSELING CODES NOT ALLOWED ON THE SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5891	**RELATED BEHAVIOR INTERVENTION COUNSELING CODES NOT ALLOWED ON THE SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**259**	Frequency of service.
5891	**RELATED BEHAVIOR INTERVENTION COUNSELING CODES NOT ALLOWED ON THE SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
5892	**CONCURRENT INFUSION ADD ON CODE MUST BE BILLED WITH PRIMARY 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.	**MA66**	Missing-incomplete-invalid principal procedure code.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
5892	**CONCURRENT INFUSION ADD ON CODE MUST BE BILLED WITH PRIMARY 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.	**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.

5892	**CONCURRENT INFUSION ADD ON CODE MUST BE BILLED WITH PRIMARY 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.	**N122**	Add-on code cannot be billed by itself.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
5892	**CONCURRENT INFUSION ADD ON CODE MUST BE BILLED WITH PRIMARY 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.	**MA66**	Missing-incomplete-invalid principal procedure code.	**465**	Principal Procedure Code for Service(s) Rendered
5892	**CONCURRENT INFUSION ADD ON CODE MUST BE BILLED WITH PRIMARY 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.	**M51**	Missing-incomplete-invalid procedure code(s).	**465**	Principal Procedure Code for Service(s) Rendered

5892	**CONCURRENT INFUSION ADD ON CODE MUST BE BILLED WITH PRIMARY 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.	**N122**	Add-on code cannot be billed by itself.	**465**	Principal Procedure Code for Service(s) Rendered
5893	**DIAGNOSTIC ASPIRATION NOT ALLOWED ON SAME DATE OF SERVICE AS RELATED DIAGNOSTIC PROCEDURES**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5893	**DIAGNOSTIC ASPIRATION NOT ALLOWED ON SAME DATE OF SERVICE AS RELATED DIAGNOSTIC PROCEDURES**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
5893	**DIAGNOSTIC ASPIRATION NOT ALLOWED ON SAME DATE OF SERVICE AS RELATED DIAGNOSTIC PROCEDURES**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5893	**DIAGNOSTIC ASPIRATION NOT ALLOWED ON SAME DATE OF SERVICE AS RELATED DIAGNOSTIC PROCEDURES**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5893	**DIAGNOSTIC ASPIRATION NOT ALLOWED ON SAME DATE OF SERVICE AS RELATED DIAGNOSTIC PROCEDURES**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
5893	**DIAGNOSTIC ASPIRATION NOT ALLOWED ON SAME DATE OF SERVICE AS RELATED DIAGNOSTIC PROCEDURES**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.

5894	**RELATED DIAGNOSTIC PROCEDURE NOT ALLOWED ON SAME DATE OF SERVICE AS DIAGNOSTIC ASPIRATION PROCEDURE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5894	**RELATED DIAGNOSTIC PROCEDURE NOT ALLOWED ON SAME DATE OF SERVICE AS DIAGNOSTIC ASPIRATION PROCEDURE**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
5894	**RELATED DIAGNOSTIC PROCEDURE NOT ALLOWED ON SAME DATE OF SERVICE AS DIAGNOSTIC ASPIRATION PROCEDURE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5894	**RELATED DIAGNOSTIC PROCEDURE NOT ALLOWED ON SAME DATE OF SERVICE AS DIAGNOSTIC ASPIRATION PROCEDURE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5894	**RELATED DIAGNOSTIC PROCEDURE NOT ALLOWED ON SAME DATE OF SERVICE AS DIAGNOSTIC ASPIRATION PROCEDURE**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
5894	**RELATED DIAGNOSTIC PROCEDURE NOT ALLOWED ON SAME DATE OF SERVICE AS DIAGNOSTIC ASPIRATION PROCEDURE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5895	**RELATED RADIOSURGERY PROCEDURE NOT ALLOWED SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

5895	**RELATED RADIOSURGERY PROCEDURE NOT ALLOWED SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
5895	**RELATED RADIOSURGERY PROCEDURE NOT ALLOWED SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5895	**RELATED RADIOSURGERY PROCEDURE NOT ALLOWED SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5895	**RELATED RADIOSURGERY PROCEDURE NOT ALLOWED SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
5895	**RELATED RADIOSURGERY PROCEDURE NOT ALLOWED SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5896	**RELATED STEREOTACTIC SERVCES NOT ON THE SAME DOS**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5896	**RELATED STEREOTACTIC SERVCES NOT ON THE SAME DOS**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
5896	**RELATED STEREOTACTIC SERVCES NOT ON THE SAME DOS**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5896	**RELATED STEREOTACTIC SERVCES NOT ON THE SAME DOS**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.

5896	**RELATED STEREOTACTIC SERVCES NOT ON THE SAME DOS**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
5896	**RELATED STEREOTACTIC SERVCES NOT ON THE SAME DOS**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5897	**RELATED STEREOTACTC SERVICE NOT ALLOWED SAME DAY AS RELATED**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5897	**RELATED STEREOTACTC SERVICE NOT ALLOWED SAME DAY AS RELATED**	**169**	Alternate benefit has been provided.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
5897	**RELATED STEREOTACTC SERVICE NOT ALLOWED SAME DAY AS RELATED**	**169**	Alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5897	**RELATED STEREOTACTC SERVICE NOT ALLOWED SAME DAY AS RELATED**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5897	**RELATED STEREOTACTC SERVICE NOT ALLOWED SAME DAY AS RELATED**	**169**	Alternate benefit has been provided.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
5897	**RELATED STEREOTACTC SERVICE NOT ALLOWED SAME DAY AS RELATED**	**169**	Alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5898	**RELATED INJECTION PROCEDURES NOT ALLOWED ON SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
5898	**RELATED INJECTION PROCEDURES NOT ALLOWED ON SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.

5898	**RELATED INJECTION PROCEDURES NOT ALLOWED ON SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5898	**RELATED INJECTION PROCEDURES NOT ALLOWED ON SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
5898	**RELATED INJECTION PROCEDURES NOT ALLOWED ON SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
5898	**RELATED INJECTION PROCEDURES NOT ALLOWED ON SAME DATE OF SERVICE**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
5899	**RADIOSURGERY ADD-ON CODE MUST BE BILLED WITH PRIMARY**	**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).	**454**	Procedure code for services rendered.
5899	**RADIOSURGERY ADD-ON CODE MUST BE BILLED WITH PRIMARY**	**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.	**N122**	Add-on code cannot be billed by itself.	**454**	Procedure code for services rendered.

5899	**RADIOSURGERY ADD-ON CODE MUST BE BILLED WITH PRIMARY**	**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.
5899	**RADIOSURGERY ADD-ON CODE MUST BE BILLED WITH PRIMARY**	**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.	**N122**	Add-on code cannot be billed by itself.	**465**	Principal Procedure Code for Service(s) Rendered.
5900	**SPINAL STEREOTACTIC RADIOSURGERY ADD-ON CODE MUST BE BILLED WITH PRIMARY 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.	**M51**	Missing-incomplete-invalid procedure code(s).	**454**	Procedure code for services rendered.

5900	**SPINAL STEREOTACTIC RADIOSURGERY ADD-ON CODE MUST BE BILLED WITH PRIMARY 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.	**N122**	Add-on code cannot be billed by itself.	**454**	Procedure code for services rendered.
5900	**SPINAL STEREOTACTIC RADIOSURGERY ADD-ON CODE MUST BE BILLED WITH PRIMARY 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	**M51**	Missing-incomplete-invalid procedure code(s).	**465**	Principal Procedure Code for Service(s) Rendered.
					between this service-procedure-		

5901	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LMITED TO ONE UNIT PER MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
5901	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LMITED TO ONE UNIT PER MONTH**	**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	**585**	Denied Charge or Non-covered Charge
5902	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO TWO UNIT PER MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
5902	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO TWO UNIT PER MONTH**	**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	**258**	Days-units for procedure-revenue code.
5902	**SERVICE DENIED. PDN IOU**	**119**	Benefit maximum for this time	**M86**	Service denied because	**585**	Denied Charge or Non-
					between this service-procedure-		

5903	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO THREE UNITS PER MONTH**	**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	**585**	Denied Charge or Non-covered Charge
5904	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO FOUR UNITS PER MONTH.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
5904	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO FOUR UNITS PER MONTH.**	**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	**258**	Days-units for procedure-revenue code.
5904	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO FOUR UNITS PER MONTH.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
			Benefit maximum for this time		Time frame requirements		Denied Charge or Non-
					between this service-procedure-		

5906	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 10 UNITS PER MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
5906	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 10 UNITS PER MONTH**	**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	**258**	Days-units for procedure-revenue code.
5906	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 10 UNITS PER MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
5906	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 10 UNITS PER MONTH**	**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	**585**	Denied Charge or Non-covered Charge
					between this service-procedure-		

5908	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 16 UNITS PER MONTH**	**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	**258**	Days-units for procedure-revenue code.
5908	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 16 UNITS PER MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
5908	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 16 UNITS PER MONTH**	**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	**585**	Denied Charge or Non-covered Charge
5909	**SERVICE DENIED. PDN IPU MEDICAL SUPPLIES LIMITED TO 20 UNITS PER MONTH.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
					between this service-procedure-		

5910	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 25 UNITS PER MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
5910	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 25 UNITS PER MONTH**	**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	**585**	Denied Charge or Non-covered Charge
5911	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMTIED TO 30 UNITS PER MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
5911	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMTIED TO 30 UNITS PER MONTH**	**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	**258**	Days-units for procedure-revenue code.
					between this service-procedure-		

5912	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 31 UNITS PER MONTH**	**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	**585**	Denied Charge or Non-covered Charge
5913	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 36 UNITS PER MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
5913	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 36 UNITS PER MONTH**	**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	**258**	Days-units for procedure-revenue code.
5913	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 36 UNITS PER MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
5913	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED**	**119**	Benefit maximum for this time period or occurrence has been	**N357**	Time frame requirements between this service-procedure-	**585**	Denied Charge or Non-covered Charge
					between this service-procedure-		

5915	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 65 UNITS PER MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
5915	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 65 UNITS PER MONTH**	**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	**258**	Days-units for procedure-revenue code.
5915	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 65 UNITS PER MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
5915	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 65 UNITS PER MONTH**	**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	**585**	Denied Charge or Non-covered Charge
5916	**Service denied. PDN IOU**	**119**	Benefit maximum for this time	**M86**	Service denied because	**258**	Days-units for procedure-
					between this service-procedure-		

5917	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 90 UNITS PER MONTH**	**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	**258**	Days-units for procedure-revenue code.
5917	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 90 UNITS PER MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
5917	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 90 UNITS PER MONTH**	**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	**585**	Denied Charge or Non-covered Charge
5918	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 93 UNITS PER MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
5918	**SERVICE DENIED. PDN IOU**	**119**	Benefit maximum for this time	**N357**	Time frame requirements	**258**	Days-units for procedure-
					between this service-procedure-		

5919	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 192 UNITS PER MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
5919	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 192 UNITS PER MONTH**	**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	**585**	Denied Charge or Non-covered Charge
5920	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 200 UNITS PER MONTH**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
5920	**SERVICE DENIED. PDN IOU MEDICAL SUPPLIES LIMITED TO 200 UNITS PER MONTH**	**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	**258**	Days-units for procedure-revenue code.
					between this service-procedure-		

5921	**PDN IOU MEDICAL SUPPLIES LIMITED TO ONE UNIT PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5922	**PDN IOU MEDICAL SUPPLIES LIMITED TO TWO UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5922	**PDN IOU MEDICAL SUPPLIES LIMITED TO TWO UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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	**258**	Days-units for procedure-revenue code.
					between this service-procedure-		

5923	**PDN IOU MEDICAL SUPPLIES LIMITED TO THREE UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5924	**PDN IOU MEDICAL SUPPLIES LIMITED TO FOUR UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5924	**PDN IOU MEDICAL SUPPLIES LIMITED TO FOUR UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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	**258**	Days-units for procedure-revenue code.
5924	**PDN IOU MEDICAL SUPPLIES LIMITED TO FOUR UNITS PER MONTH. UNITS CUTBACK TO**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within	**259**	Frequency of service.
					between this service-procedure-		

5925	**PDN IOU MEDICAL SUPPLIES LIMITED TO SIX UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5926	**PDN IOU MEDICAL SUPPLIES LIMITED TO 10 UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5926	**PDN IOU MEDICAL SUPPLIES LIMITED TO 10 UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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	**258**	Days-units for procedure-revenue code.
5926	**PDN IOU MEDICAL SUPPLIES LIMITED TO 10 UNITS PER MONTH. UNITS CUTBACK TO**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within	**259**	Frequency of service.
					between this service-procedure-		

5927	**PDN IOU MEDICAL SUPPLIES LIMITED TO 15 UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5928	**PDN IOU MEDICAL SUPPLIES LIMITED TO 16 UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5928	**PDN IOU MEDICAL SUPPLIES LIMITED TO 16 UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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	**258**	Days-units for procedure-revenue code.
5928	**PDN IOU MEDICAL SUPPLIES LIMITED TO 16 UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
					between this service-procedure-		

5929	**PDN IOU MEDICAL SUPPLIES LIMITED TO 20 UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5930	**PDN IOU MEDICAL SUPPLIES LIMITED TO 25 UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5930	**PDN IOU MEDICAL SUPPLIES LIMITED TO 25 UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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	**258**	Days-units for procedure-revenue code.
5930	**PDN IOU MEDICAL SUPPLIES LIMITED TO 25 UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
					between this service-procedure-		

5932	**PDN IOU MEDICAL 31 UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5932	**PDN IOU MEDICAL 31 UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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	**258**	Days-units for procedure-revenue code.
5932	**PDN IOU MEDICAL 31 UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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.
5932	**PDN IOU MEDICAL 31 UNITS PER MONTH. UNITS CUTBACK TO ALLOWED AMOUNT**	**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	**259**	Frequency of service.
					between this service-procedure-		

5934	**PDN IOU Medical 60 units per month. Units cutback to allowed amount.**	**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	**258**	Days-units for procedure-revenue code.
5934	**PDN IOU Medical 60 units per month. Units cutback to allowed amount.**	**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.
5934	**PDN IOU Medical 60 units per month. Units cutback to allowed amount.**	**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.
5935	**PDN IOU Medical 65 units per month. Units cutback to**	**119**	Benefit maximum for this time period or occurrence has been	**M86**	Service denied because payment already made for	**258**	Days-units for procedure-revenue code.
					between this service-procedure-		

5936	**PDN IOU Medical 80 units per month. Units cutback to allowed amount.**	**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.
5936	**PDN IOU Medical 80 units per month. Units cutback to allowed amount.**	**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.
5937	**PDN IOU Medical 90 units per month. Units cutback to allowed amount.**	**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.
5937	**PDN IOU Medical 90 units per month. Units cutback to allowed amount.**	**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-	**258**	Days-units for procedure-revenue code.
					between this service-procedure-		

5938	**PDN IOU Medical 93 units per month. Units cutback to allowed amount.**	**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.
5939	**PDN IOU Medical 192 units per month. Units cutback to allowed amount.**	**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.
5939	**PDN IOU Medical 192 units per month. Units cutback to allowed amount.**	**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	**258**	Days-units for procedure-revenue code.
5939	**PDN IOU Medical 192 units per month. Units cutback to**	**119**	Benefit maximum for this time period or occurrence has been	**M86**	Service denied because payment already made for	**259**	Frequency of service.
					between this service-procedure-		

5941	**Service Denied. PDN IOU Medical supplies limited to one unit per six months.**	**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.
5941	**Service Denied. PDN IOU Medical supplies limited to one unit per six months.**	**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	**258**	Days-units for procedure-revenue code.
5941	**Service Denied. PDN IOU Medical supplies limited to one unit per six months.**	**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.
5941	**Service Denied. PDN IOU Medical supplies limited to one unit per six months.**	**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-	**259**	Frequency of service.
					between this service-procedure-		

5943	**PDN IOU medical supplies limited to one unit per six months. Units cutback to allowed amount.**	**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	**258**	Days-units for procedure-revenue code.
5943	**PDN IOU medical supplies limited to one unit per six months. Units cutback to allowed amount.**	**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.
5943	**PDN IOU medical supplies limited to one unit per six months. Units cutback to allowed amount.**	**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.
5944	**Service Denied. PDN IOU medical supplies limited to three**	**119**	Benefit maximum for this time period or occurrence has been	**M86**	Service denied because payment already made for	**258**	Days-units for procedure-revenue code.
					between this service-procedure-		

5945	**Service Denied. PDN IOU medical supplies limited to 100 units per month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**585**	Denied Charge or Non-covered Charge
5945	**Service Denied. PDN IOU medical supplies limited to 100 units per month.**	**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	**585**	Denied Charge or Non-covered Charge
5946	**PDN IOU medical supplies limited to three units per six months. Units cutback to allowed amount.**	**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.
5946	**PDN IOU medical supplies limited to three units per six months. Units cutback to**	**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-	**258**	Days-units for procedure-revenue code.
					between this service-procedure-		

5947	**PDN IOU medical supplies limited to 100 units per month. Units cutback to allowed amount.**	**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.
5948	**Unlisted home visit service limited to four per 85 days. Units cutback to allowed amount**	**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.
5948	**Unlisted home visit service limited to four per 85 days. Units cutback to allowed amount**	**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	**258**	Days-units for procedure-revenue code.
5948	**Unlisted home visit service limited to four per 85 days. Units cutback to allowed amount**	**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.
					between this service-procedure-		

5955	**Detail priced according to multiple surgery guidelines.**	**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.
5955	**Detail priced according to multiple surgery guidelines**	**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
5957	**Units cutback. Exceeds maximum units allowed per calender month by the same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
5959	**Units cutback to the maximum units allowed per calendar month by the same or different provider**	**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.
5961	**Exceeds units allowed per calendar week**	**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.
5961	**Exceeds units allowed 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.
5961	**Exceeds units allowed per calendar week**	**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.
5961	**Exceeds units allowed 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.	**483**	Maximum coverage amount met or exceeded for benefit period.

5962	**Services not allowed on same date**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
5962	**Services not allowed on same date**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
5962	**Services not allowed on same date**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
5962	**Services not allowed on same date**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
5963	**Exceeds units allowed per calendar week without prior approval.**	**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.
5963	**Exceeds units allowed per calendar week without prior approval.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5963	**Exceeds units allowed per calendar week without prior approval.**	**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.
5963	**Exceeds units allowed per calendar week without prior approval.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
5964	**Exceeds unit limitation per calendar 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.	**259**	Frequency of service.
5964	**Exceeds unit limitation per calendar year.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
5964	**Exceeds unit limitation per calendar 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.

5964	**Exceeds unit limitation per calendar year.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
5965	**Exceeds unit limitation per calendar week.**	**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.
5965	**Exceeds unit limitation 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.
5965	**Exceeds unit limitation per calendar week.**	**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.
5965	**Exceeds unit limitation 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.	**483**	Maximum coverage amount met or exceeded for benefit period.
5966	**Exceeds the maximum units allowed per day by the same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
					between this service-procedure-		

5969	**Service Denied. Orthotic or Prosthetic Equipment allowed once every 18 months for ages 000-005**	**A1**	Claim-Service denied	**N129**	Not eligible due to the patients age.	**483**	Maximum coverage amount met or exceeded for benefit period.
5969	**Service Denied. Orthotic or Prosthetic Equipment allowed once every 18 months for ages 000-005**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**483**	Maximum coverage amount met or exceeded for benefit period.
5970	**Service Denied. Orthotic or Prosthetic Equipment allowed once per three years for ages 006-115**	**A1**	Claim-Service denied	**N129**	Not eligible due to the patients age.	**259**	Frequency of service.
5970	**Service Denied. Orthotic or Prosthetic Equipment allowed once per three years for ages 006-115**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**259**	Frequency of service.
					between this service-procedure-		

5971	**Service Denied. Orthotic or Prosthetic Equipment allowed six per year for ages 000-002.**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**483**	Maximum coverage amount met or exceeded for benefit period.
5972	**Service Denied. Orthotic or Prosthetic Equipment allowed once per two years for ages 003-115.**	**A1**	Claim-Service denied	**N129**	Not eligible due to the patients age.	**259**	Frequency of service.
5972	**Service Denied. Orthotic or Prosthetic Equipment allowed once per two years for ages 003-115.**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**259**	Frequency of service.
5972	**Service Denied. Orthotic or Prosthetic Equipment allowed once per two years for ages 003-115.**	**A1**	Claim-Service denied	**N129**	Not eligible due to the patients age.	**483**	Maximum coverage amount met or exceeded for benefit period.
					between this service-procedure-		

5988	**Injection allowed 96 units per day. Same or different provider. Cutback units to allowed amount**	**119**	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.
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**
6002	**Cardiac Rehab services are limited to 1 per day, same or different provider.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
6002	**Cardiac Rehab services are limited to 1 per day, same or**	**119**	Benefit maximum for this time period or occurrence has been	**N357**	Time frame requirements between this service-procedure-	**258**	Days-units for procedure-revenue code.
					between this service-procedure-		

6003	**Service Denied, cardiac rehab services have exceeded the 36 unit within 90 day limit, same or different provider.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
6003	**Service Denied, cardiac rehab services have exceeded the 36 unit within 90 day limit, same or different provider.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
6003	**Service Denied, cardiac rehab**	**119**	Benefit maximum for this time	**N357**	Time frame requirements between this service-procedure-	**259**	Frequency of service.

6006	**Exceeds calendar month limitation**	**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.
6006	**Exceeds calendar month 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.
6006	**Exceeds calendar month limitation**	**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.
6006	**Exceeds calendar month 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.	**483**	Maximum coverage amount met or exceeded for benefit period.
6007	**Accommodation units of svc are not consistent with DOS, patient status, and-or covered days. Correct and resubmit.**	**125**	Submission-billing error(s)	**MA130**	our 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.
6009	**Service exceeds the 16 units per date of service limitation**	**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.
6009	**Service exceeds the 16 units per date of service 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.
6009	**Service exceeds the 16 units per date of service limitation**	**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.
6009	**Service exceeds the 16 units per date of service 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.	**483**	Maximum coverage amount met or exceeded for benefit period.
6010	**Service units cutback to the allowable 16 unit limitation per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

6010	**Service units cutback to the allowable 16 unit limitation per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
6010	**Service units cutback to the allowable 16 unit limitation per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**483**	Maximum coverage amount met or exceeded for benefit period.
6010	**Service units cutback to the allowable 16 unit limitation per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
6011	**Enter correct bill type 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.
6012	**Encounter: Sterilization under both general anesthesia and epidural anesthesia not allowed on the same day.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6014	**Encounter: Delivery under both general anesthesia and epidural anesthesia not allowed on the same day.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6015	**COCHLEAR DEVICE IMPLANTATION REQUIRES PRIOR APPROVAL FOR SECOND PROCEDURE**	**197**	Precertification-authorization-notification absent.	**M62**	Missing-incomplete-invalid treatment authorization code.	**252**	Authorization-certification number.
6015	**COCHLEAR DEVICE IMPLANTATION REQUIRES PRIOR APPROVAL FOR SECOND PROCEDURE**	**197**	Precertification-authorization-notification absent.	**M62**	Missing-incomplete-invalid treatment authorization code.	**490**	Other Procedure Code for Service(s) Rendered

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.
6020	**Encounter: Duplicate billing of a base trip has previously been paid.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6022	**Encounter: Duplicate billing of a miles code has previously been paid. If units were previously billed incorrectly, void and replace previous claim.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6023	**Units Cutback. Exceeds the allowable 42 units per day 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.	**258**	Days-units for procedure-revenue code.
6023	**Units Cutback. Exceeds the allowable 42 units per day 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.
6024	**Procedure code is not covered for this date of service. Use current code.**	**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.
6024	**Procedure code is not covered for this date of service. Use current code.**	**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.
6024	**Procedure code is not covered for this date of service. Use current code.**	**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.	**457**	Non-Covered Day(s)

6024	**Procedure code is not covered for this date of service. Use current code.**	**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.	**457**	Non-Covered Day(s)
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.
6033	**Exceeds 42 units per day limitation**	**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.
6033	**Exceeds 42 units per day 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.
6034	**Exceeds 25 units per day limitation**	**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.
6034	**Exceeds 25 units per day 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.
6035	**Exceeds 6 units per 270 days limitation**	**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.
6035	**Exceeds 6 units per 270 days 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.
6057	**Drug limited to 11,300 units per treatment day same or different provider, units cutback to maximun allowed**	**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.

6058	**Drug limited to 132,000 units per calendar month same or different provider, units cutback to maximum allowed**	**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.
6060	**Admit hour-time of pickup is missing or invalid. Please correct 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.
6067	**Date of next Health Check screening missing, invalid or not in required mm-dd-yy format .**	**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.
6069	**Diagnosis modifier missing or invalid for diagnosis code (s). Health Check visit requires each listed diagnosis to have a corresponding modifier. V20.2 must be primary diagnosis.**	**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.
6070	**Only one diagnosis modifier allowed per diagnosis code. 1n not allowed in conjunction with another diagnosis modifier such as 2E, etc.**	**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.
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.
6074	**PROCEDURE ALLOWED ONCE PER DAY UNLESS BILLED WITH APPROPRIATE MODIFIERS, SAME OR DIFFERENT PROVIDER**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
6074	**PROCEDURE ALLOWED ONCE PER DAY UNLESS BILLED WITH APPROPRIATE MODIFIERS, SAME OR DIFFERENT PROVIDER**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
6075	**THIS REPEAT PROCEDURE MODIFIER COMBINATION ALLOWED ONCE PER DAY, SAME OR DIFFERENT PROVIDER**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
6075	**THIS REPEAT PROCEDURE MODIFIER COMBINATION ALLOWED ONCE PER DAY, SAME OR DIFFERENT PROVIDER**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount

6076	**Encounter: Audiometry components billed for same DOS must be combined as 92557. 92553 & 92556 have been billed. Void both & rebill using 92557.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
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**
					between this service-procedure-		

6091	**Units Cutback. Exceeds maximum units allowed per day same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
6092	**Exceeds maximum units allowed per calendar month same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
					between this service-procedure-		

6102	**Encounter: Sterilization under both general anesthesia and epidural anesthesia not allowed on the same day.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6103	**Encounter: Epidural code 62278-62279 has been paid on a separate claim. Payment for W8208-00955 includes the epidural. 62278-62279 has been**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
					between this service-procedure-		

6133	**RC636 must be billed with approved HCPCS code detailing the drug administered.**	**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.
6134	**Units Cutback. Exceeds the allowable 25 units per day 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.	**258**	Days-units for procedure-revenue code.
6134	**Units Cutback. Exceeds the allowable 25 units per day 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.
6135	**Units Cutback. Exceeds the allowable 6 units per 270 days 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.	**258**	Days-units for procedure-revenue code.
6135	**Units Cutback. Exceeds the allowable 6 units per 270 days 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.
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.
6140	**Admit date and 'from' DOS not consistent with 3rd digit-frequency code of bill type. Enter correct bill type, admit date or 'from' DOS 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.

6142	**Units of SVC are not consistent with services billed. If dates are not consecutive, list each DOS on a separate line. Correct and resubmit.**	**151**	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	**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.
6164	**MEDICAL NECESSITY IS NOT APPARENT OR SERVICE IS NOT COVERED FOR THIS DIAGNOSIS**	**50**	These are non-covered services because this is not deemed a `medical necessity by the payer.	**N180**	This item or service does not meet the criteria for the category under which it was billed	**287**	Medical necessity for service.
6170	**Encounter: Urinalysis components billed for the same DOS must be combined under 81000. 81015 & 81002 have been billed. Void both & rebill using 81000.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6171	**Vaccine limited to one per day same or different provider, units cutback to maximum allowed**	**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.**
6175	**Dialysis facility; this revenue code must be billed with the appropriate 5 digit CPT code. Correct denied detail 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.

6177	**Encounter: HCPCS code required with RC250. If HCPC code was billed, this drug is included in monthly dialysis.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
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**
6202	**DRG-admission hour and-or discharge hour is invalid. Correct 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.
6205	**Special services denied, circumstances for use of this code are not substantiated in the diagnosis.**	**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.
6215	**DRG-patient status is not valid with 3rd digit frequency of type of bill. Correct patient status or bill type 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.
6224	**Encounter: unlisted procedures are non-covered. Correct claim & resubmit.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6249	**Encounter: all encounter pdn services for same date of service must be billed on same claim.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**

6251	**Encounter: multiple encounter er visits not allowed same date of service, same provider specialty.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6254	**Encounter: service denied. Component of ekg previously paid this DOS.**		**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.
6265	**Encounter follow-up care referred to optometrist. Rebill using code W9931, W9941, or W9951.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6266	**Encounter dialysis treatment allowed once per day.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
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
6305	**When billing with mod 55, postoperative from and to dates**	**125**	Submission-billing error(s)	**MA130**	Your claim contains incomplete and-or invalid information, and	**21**	Missing or invalid information. Note- At least one other status
	Verify principal-other procedure						

6321	**DRG-Principal or other procedure code invalid for recipient sex. Verify MID and procedures. Correct and resubmit.**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.
6321	**DRG-Principal or other procedure code invalid for recipient sex. Verify MID and procedures. Correct and resubmit.**	**7**	The procedure-revenue code is inconsistent with the patients gender. 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.	**256**	DRG code(s).
6321	**DRG-Principal or other procedure code invalid for recipient sex. Verify MID and procedures. Correct and resubmit.**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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	**256**	DRG code(s).
6321	**DRG-Principal or other procedure code invalid for recipient sex. Verify MID and procedures. Correct and resubmit.**	**7**	The procedure-revenue code is inconsistent with the patients gender. 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
6321	**DRG-Principal or other procedure code invalid for recipient sex. Verify MID and procedures. Correct and resubmit.**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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	**454**	Procedure code for services rendered
6336	**Interim claims not accepted for encounter data. Verify bill type and from-to dates of service.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**

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**
6339	**Revenue code is invalid for this type bill.**	**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.
6361	**Encounter: no charges billed. Enter billed amount and resubmit. If reporting Health Check immunization, verify modifier.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6386	**Encounter: office visit-consult already paid in history.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6389	**Encounter adult health screening includes labs.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6397	**Encounter: dilation and curettage included in biopsy of cervix, circumferential cone with or without D&C.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6420	**DRG-admitting-principal-or other diagnosis code is invalid or requires further subdivision. Correct and resubmit.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**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.

6420	**DRG-admitting-principal-or other diagnosis code is invalid or requires further subdivision. Correct 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.
6421	**DRG-other diag. Code(s) duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**MA66**	Missing-incomplete-invalid principal procedure code or date.	**54**	Duplicate of a previously processed claim-line.
6421	**DRG-other diag. Code(s) duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**MA66**	Missing-incomplete-invalid principal procedure code or date.	**256**	DRG code(s.)
6421	**DRG-other diag. Code(s) duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**MA66**	Missing-incomplete-invalid principal procedure code or date.	**465**	Principal Procedure Code for Service(s) Rendered.
6423	**DRG - Admitting-Principal-or other diagnosis code is invalid for recipient sex. Correct and resubmit.**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M64**	Missing-incomplete-invalid other diagnosis.	**86**	Diagnosis and patient gender mismatch.
6423	**DRG - Admitting-Principal-or other diagnosis code is invalid for recipient sex. Correct and resubmit.**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M76**	Missing-incomplete-invalid diagnosis or conditions.	**86**	Diagnosis and patient gender mismatch.
6423	**DRG - Admitting-Principal-or other diagnosis code is invalid for recipient sex. Correct and resubmit.**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**MA65**	Missing-incomplete-invalid admitting diagnosis.	**86**	Diagnosis and patient gender mismatch.

6423	**DRG - Admitting-Principal-or other diagnosis code is invalid for recipient sex. Correct and resubmit.**	**10**	The diagnosis is inconsistent with the patients gender. 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.	**86**	Diagnosis and patient gender mismatch.
6423	**DRG - Admitting-Principal-or other diagnosis code is invalid for recipient sex. Correct and resubmit.**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s.)
6423	**DRG - Admitting-Principal-or other diagnosis code is invalid for recipient sex. Correct and resubmit.**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M76**	Missing-incomplete-invalid diagnosis or conditions.	**256**	DRG code(s.)
6423	**DRG - Admitting-Principal-or other diagnosis code is invalid for recipient sex. Correct and resubmit.**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**MA65**	Missing-incomplete-invalid admitting diagnosis.	**256**	DRG code(s.)
6423	**DRG - Admitting-Principal-or other diagnosis code is invalid for recipient sex. Correct and resubmit.**	**10**	The diagnosis is inconsistent with the patients gender. 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.	**256**	DRG code(s.)
6424	**DRG-admitting-principal-or other diagnosis code is invalid for recipient age. Correct and resubmit.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
6424	**DRG-admitting-principal-or other diagnosis code is invalid for recipient age. Correct and resubmit.**	**9**	The diagnosis is inconsistent with the patients age.	**M76**	Missing-incomplete-invalid diagnosis or conditions.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

6424	**DRG-admitting-principal-or other diagnosis code is invalid for recipient age. Correct and resubmit.**	**9**	The diagnosis is inconsistent with the patients age.	**MA65**	Missing-incomplete-invalid admitting diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
6424	**DRG-admitting-principal-or other diagnosis code is invalid for recipient age. Correct and resubmit.**	**9**	The diagnosis is inconsistent with the patients age.	**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.
6424	**DRG-admitting-principal-or other diagnosis code is invalid for recipient age. Correct and resubmit.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
6424	**DRG-admitting-principal-or other diagnosis code is invalid for recipient age. Correct and resubmit.**	**9**	The diagnosis is inconsistent with the patients age.	**M76**	Missing-incomplete-invalid diagnosis or conditions.	**255**	Diagnosis code.
6424	**DRG-admitting-principal-or other diagnosis code is invalid for recipient age. Correct and resubmit.**	**9**	The diagnosis is inconsistent with the patients age.	**MA65**	Missing-incomplete-invalid admitting diagnosis.	**255**	Diagnosis code.
6424	**DRG-admitting-principal-or other diagnosis code is invalid for recipient age. Correct and resubmit.**	**9**	The diagnosis is inconsistent with the patients age.	**MA66**	Missing-incomplete-invalid principal procedure code or date.	**255**	Diagnosis code.
6425	**Encounter: previously paid procedure 52005 recouped as included in currently billed procedure 52332-52335.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6427	**Encounter: previously paid procedure 52000 recouped as included in currently billed procedure.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6434	**Encounter: components of code 52285 have been billed and paid separately.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**

6506	**Encounter: procedure denied. Bronchoplasty procedure only allowed when billed in addition to primary surgical procedure.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6528	**Encounter: combine charges and rebill using major surgery code. Indicate total time units.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6553	**Encounter: units exceed maximum allowed per day.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6604	**Encounter: maximum daily units exceeded for service. CPT description limits code to 8 units per day (1 unit=1 hr.).**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6607	**Encounter: lower partial allowed once every 10 years.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6610	**Encounter: relines allowed once every 5 years.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6616	**Encounter: upper partial allowed once every 10 years.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6633	**Encounter: only two prosthetic lens procedures allowed.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6646	**Encounter: tympanostomy includes myringotomy procedure paid previously.**		**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:800-958-5596**	**24**	Charges are covered under a capitation agreement-managed care plan		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge.
6703	**Service. covered by Kaiser Foundation Health Plan-Please contact the HMO's member service # 1-800-800-0901.**	**24**	Charges are covered under a capitation agreement-managed care plan		**No Mapping Required**	**96**	No agreement with entity.
6703	**Service. covered by Kaiser Foundation Health Plan-Please contact the HMO's member service # 1-800-800-0901.**	**24**	Charges are covered under a capitation agreement-managed care plan		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge.
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**	**96**	No agreement with entity.
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.
6710	**Encounter: maximum of two corneal transplants allowed per day.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
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.
6793	**Encounter: exceeds limitations per 365 days for therapeutic bandage lens.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6794	**Encounter: claim history shows Medicaid has previously paid for tonsillectomies for this recipient.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6866	**Encounter: physician standby service exceeds 2 hour limit. If necessary, correct detail units and resubmit.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6867	**Encounter: DME allowed once in four years.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**

6868	**Encounter: prolonged services exceeds 3 hour maximum allowed per day for all providers. If necessary, correct the number in units field and resubmit.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
6871	**Encounter: only one ambulance base and-or miles can be billed for the same DOS, same hour-time of pick up**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**
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**
6933	**Date of service is prior to 10/01/2011 for Health Choice pharmacy claim. Claims Prior to 10/01/2011 should bill to Medco. Claims after 10/01/2011 should be billed to HPES**	**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 changes	**88**	Entity not eligible for benefits for submitted dates of service. Note-This code requires use of an Entity Code.
6934	**This recipient is not eligible for this NCHC (SCHIP) service for the date of service billed**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these changes	**88**	Entity not eligible for benefits for submitted dates of service. Note-This code requires use of an Entity Code.
6935	**N1/N2 transactions are not allowed for SCHIP recipients**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these changes	**585**	Denied Charge or Non-covered Charge.
6936	**Claim denied, recipient's eligibility indicateds Health Choice for uninsured children. Claim indicates recipient/services were subject to other health care coverage**	**22**	This care may be covered by another payer per coordination of benefits.	**N196**	Alert-Patient eligible to apply for other coverage which may be primary.	**116**	Claim submitted to incorrect payer.

6942	**Safety documentation required. Go to www.documentationforsafety.com or call ACS 866-246-8505**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these changes	**1**	For more detailed information, see remittance advice.
6959	**Encounter: only one ambulance miles and-or base can be billed for the same DOS, same hour-time of pick up**		**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**
6998	**Encounter processed. Service would have suspended for medical review.**	**A1**	Claim-Service denied	**MA07**	**Alert:** The claim information has also been forwarded to Medicaid for review.	**3**	Claim has been adjudicated and is awaiting payment cycle.
6999	**Encounter processed. Service would have suspended for unit limitation review.**		**No Mapping Required**		**No Mapping Required**		**No Mapping Required**

7000	**UNITS CUTBACK. ONLY ONE UNIT ALLOWED/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.
7000	**UNITS CUTBACK. ONLY ONE UNIT ALLOWED/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
7001	**EXCEEDS 1/DAY 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.
7001	**EXCEEDS 1/DAY 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.	**612**	Per Day Limit Amount
7002	**UNITS CUTBACK. MAX. # OF UNITS/DAY(S) EXCEEDED**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
7002	**UNITS CUTBACK. MAX. # OF UNITS/DAY(S) EXCEEDED**	**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.
7002	**UNITS CUTBACK. MAX. # OF UNITS/DAY(S) EXCEEDED**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
7002	**UNITS CUTBACK. MAX. # OF UNITS/DAY(S) EXCEEDED**	**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.
7002	**UNITS CUTBACK. MAX. # OF UNITS/DAY(S) EXCEEDED**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
7002	**UNITS CUTBACK. MAX. # OF UNITS/DAY(S) EXCEEDED**	**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	**612**	Per Day Limit Amount

7003	**EXCEEDS MAXIMUM UNITS ALLOWED PER DAY(S)**	**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.
7003	**EXCEEDS MAXIMUM UNITS ALLOWED PER DAY(S)**	**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	**259**	Frequency of service.
					between this service-procedure-		

7005	**EXCEEDS MAX UNITS ALLOWED/WEEK(S)**	**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.
7005	**EXCEEDS MAX UNITS ALLOWED/WEEK(S)**	**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	**259**	Frequency of service.
					between this service-procedure-		

7008	**UNITS CUTBACK. MAX ## OF UNITS/YEAR(S) EXCEEDED**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
7008	**UNITS CUTBACK. MAX ## OF UNITS/YEAR(S) EXCEEDED**	**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.
7008	**UNITS CUTBACK. MAX ## OF**	**119**	Benefit maximum for this time	**N362**	The number of Days or Units of	**259**	Frequency of service.
					between this service-procedure-		

7010	**UNITS CUTBACK. MAX # OF UNITS/LIFETIME EXCEEDED**	**149**	Lifetime benefit maximum has been reached for this service-benefit category	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**259**	Frequency of service.
7011	**EXCEEDS MAXIMUM UNITS ALLOWED PER LIFETIME**	**149**	Lifetime benefit maximum has been reached for this service-benefit category	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
7012	**UNITS CUTBACK. MAX # OF UNITS FISCAL YEAR EXCEEDED**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code.
7012	**UNITS CUTBACK. MAX # OF UNITS FISCAL YEAR**	**119**	Benefit maximum for this time period or occurrence has been	**N381**	Consult our contractual agreement for restrictions-	**258**	Days-units for procedure-revenue code.
					between this service-procedure-		

7014	**UNITS CUTBACK. MAXIMUM NUMBER OF UNITS PER CALENDAR YEAR EXCEEDED**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
7014	**UNITS CUTBACK. MAXIMUM NUMBER OF UNITS PER CALENDAR YEAR EXCEEDED**	**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.
7015	**EXCEEDS MAXIMUM UNITS ALLOWED PER CALENDAR 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.	**259**	Frequency of service.
7015	**EXCEEDS MAXIMUM UNITS**	**119**	Benefit maximum for this time	**N357**	Time frame requirements between this service-procedure-	**259**	Frequency of service.

7017	**EXCEEDS ONE/2 YEARS 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.
7017	**EXCEEDS ONE/2 YEARS LIMIT**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
7018	**UNITS CUTBACK. MAX NUMBER OF UNITS PER GESTATION 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	**258**	Days-units for procedure-revenue code.
7018	**UNITS CUTBACK. MAX NUMBER OF UNITS PER GESTATION PERIOD**	**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.
					between this service-procedure-		

7020	**UNITS CUTBACK. MAX # UNITS/DAY FOR CAP SERVICE EXCEEDED**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount
7020	**UNITS CUTBACK. MAX # UNITS/DAY FOR CAP SERVICE EXCEEDED**	**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	**612**	Per Day Limit Amount
7021	**EXCEEDS MAX # UNITS FOR CAP SERVICE ALLOWED/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.
					between this service-procedure-		

7024	**Exceeds establisted eye exam limit of two times per year**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
7050	**Exceeds limit of one routuine eye exam and/or refraction per year for recipients under age 21 additional routine eye exam services require prior approvalbefore service is rendered**	**119**	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.
7057	**Drug limited to 11,300 units per treatment day same or different provider**	**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.
7058	**Drug limired to 132,000 units per calendar month same or different provider**	**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.
7059	**DME allowed 6 units per calendar month by the same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
7062	**DISPENSE BRAND NAME DRUG. GENERIC DRUG IS NON-PREFERRED**	**204**	This service-equipment-drug is not covered under the patients current benefit plan	**N448**	This drug-service-supply is not included in the fee schedule or contracted-legislated fee arrangement	**216**	Drug information.
7062	**DISPENSE BRAND NAME DRUG. GENERIC DRUG IS NON-PREFERRED**	**204**	This service-equipment-drug is not covered under the patients current benefit plan	**N130**	Consult plan benefit documents-guidelines for information about restrictions for this service.	**216**	Drug information.
7074	**CLAIM DENIED. CASE MANAGEMENT UNITS BILLED BY THE SAME OR DIFFERENT PROVIDER EXCEEDS ANNUAL ALLOWABLE 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.
7075	**SERVICE DENIED. UNIT LIMITATION FOR DEFILBRILLATOR HAS BEEN EXCEEDED FOR THE ALLOWED 91 DAY PERIOD, BY THE SAME OR DIFFERENT PROVIDER**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.

7082	**The maximum dollar amount allowed for this service per waiver year by the same or different provider has been exceeded**	**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
7100	**Dilation included in related laparoscopy procedure performed the same day**	**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.
7100	**Dilation included in related laparoscopy procedure performed the same day**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
7101	**Service recouped. Dilation included in related laparoscopy procedure performed the same day**	**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.
7101	**Service recouped. Dilation included in related laparoscopy procedure performed the same day**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.

7103	**Add-On procedure for Cystometrogram must be billed with a paid primary procedure for reimbursement**	**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.	**N161**	This drug-service-supply is covered only when the associated service is covered.	**454**	Procedure code for services rendered.
7103	**Add-On procedure for Cystometrogram must be billed with a paid primary procedure for reimbursement**	**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.	**N161**	This drug-service-supply is covered only when the associated service is covered.	**465**	Principal Procedure Code for Service(s) Rendered
7104	**Exceeds maximum units allowed per day**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**483**	Maximum coverage amount met or exceeded for benefit period
7105	**Exceeds maximum units allowed per month**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**483**	Maximum coverage amount met or exceeded for benefit period
7107	**Below Kneww Strapping or compression already paid for this date of service. File adjustment with supporting documentation for reconsideration if necessary**	**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.

7107	**Below Kneww Strapping or compression already paid for this date of service. File adjustment with supporting documentation for reconsideration if necessary**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
7151	**Tissue Transfer, specified site not allowed when tissue transfer "any area" billed same date of service. File adjustment supporting different areas.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service. .
7151	**Tissue Transfer, specified site not allowed when tissue transfer "any area" billed same date of service. File adjustment supporting different areas.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
7151	**Tissue Transfer, specified site not allowed when tissue transfer "any area" billed same date of service. File adjustment supporting different areas.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered
7151	**Tissue Transfer, specified site not allowed when tissue transfer "any area" billed same date of service. File adjustment supporting different areas.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered
7153	**Related cardiovascular surgery already paid for this date of service**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**M86**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7157	**Related angiography service previously paid for this date**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**M86**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.

7160	**Service recouped. Ultrasound guidance is included in the related surgical procedure performed on the same date of 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.	**M86**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
7160	**Service recouped. Ultrasound guidance is included in the related surgical procedure performed on the same date of 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.	**M86**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7161	**Service denied. Ultrasound guidance is included in the related surgical procedure performed on the same date of 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.	**M86**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
7161	**Service denied. Ultrasound guidance is included in the related surgical procedure performed on the same date of 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.	**M86**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7199	**Vestibular function test with recording already paid for this date of service**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**M86**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.

7300	**Add-On Code not allowed. Primary procedure must be paid in history for same date of service by the same attending provider**	**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 Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
7306	**OPHTHALMIC DIAGNOSTIC IMAGING DENIED, NOT ALLOWED ON THE SAME DAY AS RELATED OPHTHALMIC DIAGNOSTIC IMAGING PERFORMED BY THE SAME OR DIFFERENT PROVIDER**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
7308	**ADD ON CODE NOT ALLOWED, PRIMARY PROCEDURE MUST BE PAID IN HISTORY FOR SAME DATE OF SERVICE, BY THE SAME ATTENDING PROVIDER**	**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 Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
7309	**RELATED ENDOVASCULAR CODES NOT ALLOWED SAME DATE OF SERVICE, SAME ATTENDING PROVIDER**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.

7310	**ONLY ONE REVASCULARIZATION PROCEDURE ALLOWED PER DAY. RELATED SERVICE ALREADY PAID FOR THIS DOS**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
7311	**EXCEEDS MAXIMUM UNITS ALLOWED PER DAY, BY SAME ATTENDING PROVIDER**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
7312	**ARTHROSCOPY SURGERY CODES NOT ALLOWED SAME DATE OF SERVICE AS ARTHROSCOPY DIAGNOSTIC CODES, SAME BILLING PROVIDER**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
7313	**ARTHROSCOPIC DIAGNOSTIC CODES NOT ALLOWED SAME DATE OF SERVICE AS ARTHROSCOPIC SURGICAL CODES, SAME BILLING PROVIDER**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
7325	**ADD ON CODE NOT ALLOWED, PRIMARY PROCEDURE MUST BE PAID IN HISTORY FOR SAME DATE OF SERVICE BY THE SAME ATTENDING PROVIDER**	**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 Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.

7326	**SURGICAL PROCEDURE DENIED. RELATED SURGICAL PROCEDURES NOT ALLOWED ON THE SAME DAY BY THE SAME OR DIFFERENT PROVIDER**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
7328	**PROCEDURE DENIED. RELATED PROCEDURES NOT ALLOWED ON THE SAME DAY, BY THE SAME OR DIFFERENT PROVIDER**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
7329	**PROCEDURE RECOUPED, RELATED PROCEDURES NOT ALLOWED ON THE SAME DAY BY THE SAME OR DIFFERENT PROVIDER**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
7330	**SURGICAL PROCEDURE DENIED. RELATED SURGICAL PROCEDURES NOT ALLOWED ON THE SAME DAY BY THE SAME OR DIFFERENT PROVIDER**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
7333	**SURGICAL PROCEDURE RECOUPED. RELATED SURGICAL PROCEDURES NOT ALLOWED ON THE SAME DAY BY THE SAME OR DIFFERENT PROVIDER**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
7336	**PROCEDURE DENIED. RELATED PROCEDURES NOT ALLOWED ON THE SAME DAY, BY THE SAME ATTENDING PROVIDER**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.

7337	**PROCEDURE RECOUPED. RELATED PROCEDURES NOT ALLOWED ON THE SAME DAY, BY THE SAME ATTENDING PROVIDER**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
7338	**PROCEDURE DENIED. RELATED PROCEDURES NOT ALLOWED ON THE SAMEDAY, BY THE SAME OR DIFFERENT ATTENDING PROVIDER**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
7339	**PROCEDURE RECOUPED. RELATED PROCEDURES NOT ALLOWED ON THE SAME DAY, BY THE SAME OR DIFFERENT ATTENDING PROVIDER**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
7341	**CATHETERIZATION PROCEDURE NOT ALLOWED SAME DATE OF SERVICE AS RELATED CATHETERIZATION PROCEDURE, SAME OR DIFFERENT PROVIDER**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
7344	**INJECTION PROCEDURE NOT ALLOWED SAME DATE OF SERVICE AS CATHETERIZATION PROCEDURE, SAME OR DIFFERENT PROVIDER**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.

7345	**LEFT CATHETERIZATION PROCEDURE MUST BE BILLED WITH RELATED PRIMARY CATHETERIZATION PROCEDURE**	**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 Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
7346	**PHARMACOLOGICAL AGENT ADMINISTRATION MUST BE BILLED WITH CATHETERIZATION PROCEDURE**	**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 Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
7347	**PHYSIOLOGICAL EXERCISE STUDY MUST BE BILLED WITH CATHETERIZATION PROCEDURE**	**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 Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.

7348	**INJECTION PROCEDURE MUST BE BILLED WITH CATHETERIZATION PROCEDURE**	**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 Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
7349	**DILUTION STUDIES MUST BE BILLED WITH CATHETERIZATION PROCEDURE**	**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 Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N19**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
7351	**CATHETERIZATION PROCEDURE RECOUPED WHEN RELATED CATHETERIZATION PROCEDURE PAID ON SAME DATE OF SERVICE, SAME OR DIFFERENT PROVIDER**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
7354	**RECOUP INJECTION PROCEDURE WHEN CATHETERIZATION PROCEDURE ALREADY PAID ON SAME DATE OF SERVICE SAME OR DIFFERENT PROVIDER**	**169**	Alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

7355	**SERVICE DENIED. EXCEEDS MAXIMUM UNITS ALLOWED**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within	**612**	Per Day Limit Amount
					between this service-procedure-		

7363	**COMPLETE ULTRASOUND OF EXTREMETIES NOT ALLOWED SAME DAY AS LIMITED ULTRASOUND OF EXTREMETIES, SAME OR DIFFERENT PROVIDER**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
7364	**ADDITIONAL IMMUNIZATION ADMINISTRATION REQUIRES PRIMARY ADMINISTRATION TO BE PAID FIRST SAME ATTENDING PROVIDER**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
7365	**HEALTH CHECK IMMUNIZATION ADMINISTRATIONS LIMITED TO 14 UNITS PER DAY, SAME OR DIFFERENT PROVIDER**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
7366	**IMMUNIZATION ADMINISTRATIONS LIMITED TO 9 UNITS PER DAY, SAME OR DIFFERENT PROVIDER**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
7367	**THE E/M SERVICE BILLED IS DENIED. ANOTHER E/M PROCEDURE PREVIOUSLY PAID FOR THIS ATTENDING PROVIDER FOR THIS DATE OF SERVICE**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
7369	**OPHTHALMOSCOPY NOT ALLOWED SAME DAY AS E/M OF THE EYE, SAME ATTENDING PROVIDER**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.

7370	**OPHTHALMOSCOPY**	**169**	Alternate benefit has been	**M80**	Not covered when performed	**187**	Date(s) of service.
					between this service-procedure-		

7403	**Manual therapy not allowed same day as application of compression system, same billing provider**	**A1**	Claim-Service denied. At least one Remark Code must be provided may be comprised of either the NCPDP Reject Reason	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifiers for Services Rendered
					between this service-procedure-		

7406	**Removal of lung not allowed same day as thoracotomy, same or different provider**	**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	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifiers for Services Rendered
					between this service-procedure-		

7409	**Lung removal not allowed same day as thoracoscopy, same or different provider**	**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	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifiers for Services Rendered
					between this service-procedure-		

7411	**Lung volume reduction ot allowed same day as thoracoscopy, same attending and same billing provider**	**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	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Dates of service
					between this service-procedure-		

7412	**Resection of thymus not allowed same day as thymectomy, same attending and same billing provider**	**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	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifiers for Services Rendered
					between this service-procedure-		

7414	**Related lymphadenectomy not allowed same day, same billing and same attending provider**	**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	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Dates of service
					between this service-procedure-		

7416	**Insertion and removal of pacemaker not allowed same day, same billing provider**	**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	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Dates of service
					between this service-procedure-		

7417	**Removal of pacemaker not allowed same day as upgrade of pacemaker, same billing provider**	**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	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifiers for Services Rendered
					between this service-procedure-		

7419	**Insertion of pulse generator not allowed same day as removal of pulse generator, same billing provider**	**A1**	Claim-Service denied. At least one Remark Code must be provided may be comprised of either the NCPDP Reject Reason	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Dates of service
					between this service-procedure-		

7420	**Removal of pulse generator not allowed same day as removal of pulse generator, same billing**	**A1**	Claim-Service denied. At least one Remark Code must be provided may be comprised of	**M86**	Service denied because payment already made for same-similar procedure within	**453**	Procedure Code Modifiers for Services Rendered
					between this service-procedure-		

7422	**Repositioning of filter not allowed same day as insertion of intravascular vena cava filter, same billing provider**	**A1**	Claim-Service denied. At least one Remark Code must be provided may be comprised of either the NCPDP Reject Reason	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifiers for Services Rendered
					between this service-procedure-		

7424	**Removal of intravascular vena cava filter not allowed same day as removal of transcatheter filter, same or different**	**A1**	Claim-Service denied. At least one Remark Code must be provided may be comprised of either the NCPDP Reject Reason	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not	**453**	Procedure Code Modifiers for Services Rendered
					between this service-procedure-		

7452	**Removal of devitalized tissue not same day as application of skin substitute, same billing provider**	**A1**	Claim-Service denied. At least one Remark Code must be provided may be comprised of either the NCPDP Reject Reason	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifiers for Services Rendered
					between this service-procedure-		

7457	**Application of skin substitute not allowed same date of service as related procedure, same attending provider**	**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	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	**453**	Procedure Code Modifiers for Services Rendered
					between this service-procedure-		

7476	**Surgical procedure not allowed on same date of service as related radiological procedure,**	**A1**	Claim-Service denied. At least one Remark Code must be provided may be comprised of	**N357**	Time frame requirements between this service-procedure-supply and a related service-	**453**	Procedure Code Modifiers for Services Rendered
					between this service-procedure-		

7478	**Related abdominal paracentesis procedures not allowed on same date of service, same or**	**A1**	Claim-Service denied. At least one Remark Code must be provided may be comprised of	**N357**	Time frame requirements between this service-procedure-supply and a related service-	**187**	Dates of service
					between this service-procedure-		

7479	**Implantation procedure not allowed on same date of service as related medical maintenance**	**A1**	Claim-Service denied. At least one Remark Code must be provided may be comprised of	**N357**	Time frame requirements between this service-procedure-supply and a related service-	**453**	Procedure Code Modifiers for Services Rendered
					between this service-procedure-		

7481	**Related implantation procedures not allowed on same date of service, same or different**	**A1**	Claim-Service denied. At least one Remark Code must be provided may be comprised of	**N357**	Time frame requirements between this service-procedure-supply and a related service-	**187**	Dates of service
					between this service-procedure-		

7482	**Related tomography and fluoroscopic procedures not allowed on same date of**	**A1**	Claim-Service denied. At least one Remark Code must be provided may be comprised of	**N357**	Time frame requirements between this service-procedure-supply and a related service-	**453**	Procedure Code Modifiers for Services Rendered
					between this service-procedure-		

7484	**Only one pulmonary imaging procedure allowed per date of service by the same or different**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within	**612**	Per Day Limit Amount
					between this service-procedure-		

7486	**Myocardial imaging not allowed same day as related pulmonary**	**A1**	Claim-Service denied. At least one Remark Code must be	**N357**	Time frame requirements between this service-procedure-	**187**	Dates of service
					between this service-procedure-		

7487	**Related contact lens fitting procedures not allowed same**	**A1**	Claim-Service denied. At least one Remark Code must be	**N357**	Time frame requirements between this service-procedure-	**453**	Procedure Code Modifiers for Services Rendered
					between this service-procedure-		

7490	**Related electromyography procedures not allowed same**	**A1**	Claim-Service denied. At least one Remark Code must be	**N357**	Time frame requirements between this service-procedure-	**187**	Dates of service
					between this service-procedure-		

7492	**Related nerve conduction studies limited to 1 unit per date**	**119**	Benefit maximum for this time period or occurrence has been	**M86**	Service denied because payment already made for	**612**	Per Day Limit Amount
					between this service-procedure-		

7494	**Arthrodesis performed on the same date of service includes**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same	**259**	Frequency of service
					between this service-procedure-		

7496	**Revision of shoulder does not allow for related shoulder procedure same day, same attending provider. Related procedure recouped**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**259**	Frequency of service
7497	**Revision of shoulder procedure already paid for this date of service, by same or different provider. If procedure were performed bilaterally, submit with appropriate modifier**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**187**	Date(s) of service
7497	**Revision of shoulder procedure already paid for this date of service, by same or different provider. If procedure were performed bilaterally, submit with appropriate modifier**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**453**	Procedure Code Modifier(s) for Service(s) Rendered
7498	**Elbow procedure not allowed same day as revision of elbow by same attending provider. If services performed bilaterally, submit as an adjustment with operative notes**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**187**	Date(s) of service
7498	**Elbow procedure not allowed same day as revision of elbow by same attending provider. If services performed bilaterally, submit as an adjustment with operative notes**	**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
7498	**Elbow procedure not allowed same day as revision of elbow by same attending provider. If services performed bilaterally, submit as an adjustment with operative notes**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**187**	Date(s) of service

7498	**Elbow procedure not allowed same day as revision of elbow by same attending provider. If services performed bilaterally, submit as an adjustment with operative notes**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**453**	Procedure Code Modifier(s) for Service(s) Rendered
7499	**Revision of elbow does not allow for related elbow procedure same day, same attending provider. Related procedure recouped**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service
7499	**Revision of elbow does not allow for related elbow procedure same day, same attending provider. Related procedure recouped**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**259**	Frequency of service
7500	**Revision of elbow procedure already paid for this date of service, by the same or different provider. If procedure were performed bilaterally, submit with appropriate modifier**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**187**	Date(s) of service
7500	**Revision of elbow procedure already paid for this date of service, by the same or different provider. If procedure were performed bilaterally, submit with appropriate modifier**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**453**	Procedure Code Modifier(s) for Service(s) Rendered
7501	**Thoracentesis or pleural drainage procedure on same date of service as related procedure not allowed by same or different provider. Related procedure recouped**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service

7501	**Thoracentesis or pleural drainage procedure on same date of service as related procedure not allowed by same or different provider. Related procedure recouped**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**259**	Frequency of service
7502	**Treatment planning not allowed on same date of service as radiation therapy procedure by same or different provider**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**187**	Date(s) of service
7502	**Treatment planning not allowed on same date of service as radiation therapy procedure by same or different 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
7502	**Treatment planning not allowed on same date of service as radiation therapy procedure by same or different provider**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**187**	Date(s) of service
7502	**Treatment planning not allowed on same date of service as radiation therapy procedure by same or different provider**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**453**	Procedure Code Modifier(s) for Service(s) Rendered
7503	**Radiation therapy performed on same date of service as treatment planning by same or different provider not allowed. Treatment planning procedure recouped**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service

7503	**Radiation therapy performed on same date of service as treatment planning by same or different provider not allowed. Treatment planning procedure recouped**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**259**	Frequency of service
7504	**Catheterization is included in TAVR/TAVI procedure performed same date of service by same or different provider**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service
7504	**Catheterization is included in TAVR/TAVI procedure performed same date of service by same or different provider**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**259**	Frequency of service
7505	**Add-on code not allowed, primary procedure code must be paid in history for the same date of service**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**465**	Principal Procedure Code for Service(s) Rendered
7506	**TAVR/TAVI included in catheterization procedure performed on same date of service, same or different provider**	**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	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service

7506	**TAVR/TAVI included in catheterization procedure performed on same date of service, same or different provider**	**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	**N20**	Service not payable with other service rendered on the same date	**259**	Frequency of service
7507	**Repositioning of device is included in the insertion surgery performed on the same date of service by same or different provider**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service
7507	**Repositioning of device is included in the insertion surgery performed on the same date of service by same or different provider**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**259**	Frequency of service
7508	**Insertion procedure on same day as repositioning of device by same or different provider not allowed. Repositioning procedure recouped**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service
7508	**Insertion procedure on same day as repositioning of device by same or different provider not allowed. Repositioning procedure recouped**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**259**	Frequency of service
7509	**Only one transcatheter therapy allowed per day, same or different provider**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code

7510	**Transplantation of donor marrow not allowed same date of service as related procedure, same or different provider**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**187**	Date(s) of service
7510	**Transplantation of donor marrow not allowed same date of service as related procedure, same or different 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
7510	**Transplantation of donor marrow not allowed same date of service as related procedure, same or different provider**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**187**	Date(s) of service
7510	**Transplantation of donor marrow not allowed same date of service as related procedure, same or different provider**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**453**	Procedure Code Modifier(s) for Service(s) Rendered
7511	**Non-selective catheter placement included in selective catheter placement, same date of service, same attending provider**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service
7511	**Non-selective catheter placement included in selective catheter placement, same date of service, same attending provider**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**259**	Frequency of service

7512	**Exceeds maximum units allowed per day, same attending provider**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code
7513	**Selective catheter placement performed on same day as non-selective placement by same attending provider not allowed. Non-selective procedure recouped**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service
7513	**Selective catheter placement performed on same day as non-selective placement by same attending provider not allowed. Non-selective procedure recouped**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**259**	Frequency of service
7514	**Thoracentesis/pleural drainage procedure performed same day as related radiological procedure by same or different provider not allowed. Radiological procedure recouped**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service
7514	**Thoracentesis/pleural drainage procedure performed same day as related radiological procedure by same or different provider not allowed. Radiological procedure recouped**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**259**	Frequency of service
7515	**Based on description of procedure in records, a more specific code is available and must be billed instead of the unlisted code**	**189**	Not otherwise classified or unlisted procedure code (CPT-HCPCS) was billed when there is a specific procedure code for this procedure-service	**N350**	Missing-incomplete-invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted-By Report procedure	**454**	Procedure code for services rendered

7520	**TAVR/TAVI service does not indicate service was performed by two surgeons as required**	**A1**	Claim-Service denied	**N130**	Consult plan benefit documents-guidelines for information about restrictions for this service	**453**	Procedure Code Modifier(s) for Service(s) Rendered
7596	**Related behavioral health codes not allowed same dos, same attending**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**187**	Date(s) of service
7596	**Related behavioral health codes not allowed same dos, same attending**	**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
7596	**Related behavioral health codes not allowed same dos, same attending**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**187**	Date(s) of service
					between this service-procedure-		

7597	**Related behavioral health codes exceed daily limitation**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code
7598	**Behavioral health not allowed same day as E/M, same attending provider**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**187**	Date(s) of service
7598	**Behavioral health not allowed same day as E/M, same attending 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
7598	**Behavioral health not allowed same day as E/M, same attending provider**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**187**	Date(s) of service
					between this service-procedure-		

7599	**E/M not allowed same day as behavioral health, same attending provider**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**187**	Date(s) of service
7599	**E/M not allowed same day as behavioral health, same attending 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
7599	**E/M not allowed same day as behavioral health, same attending provider**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**187**	Date(s) of service
7599	**E/M not allowed same day as behavioral health, same attending provider**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**453**	Procedure Code Modifier(s) for Service(s) Rendered
7601	**Prolonged service not allowed same day as psychotherapy, same attending provider**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**187**	Date(s) of service

7601	**Prolonged service not allowed same day as psychotherapy, same attending 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
7601	**Prolonged service not allowed same day as psychotherapy, same attending provider**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**187**	Date(s) of service
7601	**Prolonged service not allowed same day as psychotherapy, same attending provider**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**453**	Procedure Code Modifier(s) for Service(s) Rendered
7602	**Psychotherapy not allowed on the same day as prolonged service by same or different provider. Prolonged service recouped**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service
7602	**Psychotherapy not allowed on the same day as prolonged service by same or different provider. Prolonged service recouped**	**169**	Alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**259**	Frequency of service

7603	**Crisis management unit limit exceeded per calendar year, same attending provider**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code
7604	**Crisis management not allowed same day as related behavioral health procedure, same attending provider**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**187**	Date(s) of service
7604	**Crisis management not allowed same day as related behavioral health procedure, same attending 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
					between this service-procedure-		

7605	**Behavioral health procedure not allowed same day as crisis management, same attending provider**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**187**	Date(s) of service
7605	**Behavioral health procedure not allowed same day as crisis management, same attending 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
7605	**Behavioral health procedure not allowed same day as crisis management, same attending provider**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not	**187**	Date(s) of service
					between this service-procedure-		

7607	**Comprehensive code includes related procedure, same or different provider. Component procedure recouped**	**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	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service
7608	**Add-on code not allowed, primary procedure code must be paid in history for the same date of service, by the same or different provider**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**465**	Principal Procedure Code for Service(s) Rendered
7609	**Allergy testing daily unit limit exceeded, same or different provider**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code
7610	**Sleep monitoring daily unit limit exceeded, same or different provider**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code

7611	**Nerve conduction study limited by CPT description. Rebill using correct code**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code
7612	**Nerve conduction not allowed same day as nerve studies, same attending provider**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**187**	Date(s) of service
7612	**Nerve conduction not allowed same day as nerve studies, same attending 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
					between this service-procedure-		

7612	**Nerve conduction not allowed same day as nerve studies, same attending provider**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**453**	Procedure Code Modifier(s) for Service(s) Rendered
7613	**Nerve studies not same day as nerve conduction**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**187**	Date(s) of service
7613	**Nerve studies not same day as nerve conduction**	**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
					between this service-procedure-		

7613	**Nerve studies not same day as nerve conduction**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**453**	Procedure Code Modifier(s) for Service(s) Rendered
7614	**Related function test already paid for this date of service, same or different provider**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**187**	Date(s) of service
7614	**Related function test already paid for this date of service, same or different 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
7614	**Related function test already paid for this date of service, same or different provider**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**187**	Date(s) of service

7614	**Related function test already paid for this date of service, same or different provider**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**453**	Procedure Code Modifier(s) for Service(s) Rendered
7616	**Continuous monitoring of multiple patients or outside the operating room has already been paid to this provider for this date of service**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**187**	Date(s) of service
7616	**Continuous monitoring of multiple patients or outside the operating room has already been paid to this provider for this date of service**	**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
7616	**Continuous monitoring of multiple patients or outside the operating room has already been paid to this provider for this date of service**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**187**	Date(s) of service

7616	**Continuous monitoring of multiple patients or outside the operating room has already been paid to this provider for this date of service**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**453**	Procedure Code Modifier(s) for Service(s) Rendered
7617	**Add-on code not allowed, primary procedure code must be billed in history for the same date of service, by the same attending provider**	**A1**	Claim-Service denied	**N122**	Add-on code cannot be billed by itself	**465**	Principal Procedure Code for Service(s) Rendered
7700	**The type of treatment on this detail indicates you should be billing with a specific modifier denoting the service rendered. Resubmit the detail with the appropriate modifier.**	**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.
7701	**Combination of billed modifiers is invalid. Please review and resubmit with correct billing combination.**	**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.
7702	**Medicaid does not accept one or more of the billed modifiers please correct the modifier information and resubmit. Refer to your modifier manual for assistance if necessary.**	**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.

7703	**Medicaid does not accept billing of more than 3 modifiers per procedure. Resubmit with no more than three modifiers. refer to your modifier manual for assistance if necessary.**	**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.
7704	**Provider type and specialty combination is not allowed to bill the modifier submitted. Correct and resubmit denied detail if necessary.**	**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.
7705	**Postoperative from and to dates are required when billing with modifier 55. Please correct 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.
7706	**Invalid date information (month, day, year) included as the postoperative from and to dates. Please correct & 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.
7707	**Postoperative dates begin the day following surgery. Please correct postoperative dates 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.

7708	**Postoperative dates billed are not within the postop period .**	**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.
7709	**Cardiovascular therapeutic services are not allowed unless billed with the appropriate modifier.**	**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.	**M84**	Medical code sets used must be the codes in effect at the time of service.	**258**	Days-units for procedure-revenue code.
7710	**Procedure must be rendered by an approved anesthesia provider in order to receive reimbursement from Medicaid.**	**52**	The referring-prescribing-rendering provider is not eligible to refer-prescribe-order-perform the service billed.	**N95**	This provider type - provider specialty may not bill this service.	**56**	Awaiting eligibility determination.
7711	**One single vessel service 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.
7711	**One single vessel service 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
7712	**Each add'l procedure are only allowed when a single vessel service has been billed for the same day.**	**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.	**258**	Days-units for procedure-revenue code.

7712	**Each add'l procedure are only allowed when a single vessel service has been billed for the same day.**	**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.	**258**	Days-units for procedure-revenue code.
7713	**Billing of service with mod. LC is limited to 1-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.
7713	**Billing of service with mod. LC is limited to 1-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
7714	**Billing of service with mod LD is limited to 1-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.
7714	**Billing of service with mod LD is limited to 1-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
7715	**Billing of service with mod RC is limited to 1-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.
7715	**Billing of service with mod RC is limited to 1-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
7716	**Medicaid only allows for one unit of 'other diagnostic services' to be paid per day. The maximum number of units have been paid for this 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.	**259**	Frequency of service.

7716	**Medicaid only allows for one unit of 'other diagnostic services' to be paid per day. The maximum number of units have been paid for this 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
7717	**This procedure code requires a modifier that signifies the category of class findings to be appended in order for Medicaid to consider payment. Review and resubmit 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	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
7717	**This procedure code requires a modifier that signifies the category of class findings to be appended in order for Medicaid to consider payment. Review and resubmit new claim.**	**125**	Submission-billing error(s)	**N180**	This item or service does not meet the criteria for the category under which it was billed	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
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
7719	**E&M service is included in anesthesia global package billed same day.**	**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.

7720	**Endoscopy codes from related groups billed with the date of service must be submitted on a single claim. A code from this group has previously been paid for this DOS.**	**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.
7721	**Billing for services not allowed without appropriate ambulatory surgery center modifier.**	**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.
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.
7723	**Overlapping post-op dates are not allowed during the follow-up period for a single proc. Please correct billed post-op dates.**	**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.
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

7725	**Re-bill on paper claim and attach medical records and operative notes indicating participation of all team surgeons involved for this procedure, this date of service.**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-incomplete-invalid documentation-orders-notes-summary-report-chart.	**277**	Paper claim.
7725	**Re-bill on paper claim and attach medical records and operative notes indicating participation of all team surgeons involved for this procedure, this date of service.**	**16**	Claim-service lacks information which is needed for adjudication	**N34**	Incorrect claim form-format for this service.	**277**	Paper claim.
7725	**Re-bill on paper claim and attach medical records and operative notes indicating participation of all team surgeons involved for this procedure, this date of service.**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-incomplete-invalid documentation-orders-notes-summary-report-chart.	**297**	Medical notes-report.
7725	**Re-bill on paper claim and attach medical records and operative notes indicating participation of all team surgeons involved for this procedure, this date of service.**	**16**	Claim-service lacks information which is needed for adjudication	**N34**	Incorrect claim form-format for this service.	**297**	Medical notes-report.
7725	**Re-bill on paper claim and attach medical records and operative notes indicating participation of all team surgeons involved for this procedure, this date of service.**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-incomplete-invalid documentation-orders-notes-summary-report-chart.	**298**	Operative report.
7725	**Re-bill on paper claim and attach medical records and operative notes indicating participation of all team surgeons involved for this procedure, this date of service.**	**16**	Claim-service lacks information which is needed for adjudication	**N34**	Incorrect claim form-format for this service.	**298**	Operative report.

7726	**Medicaid requires documentation for procedures appended with modifier 66 when billing over 3 units of svc. Resubmit as an adj. w/records indicating all surgeons involved this DOS.**	**16**	Claim-service lacks information which is needed for adjudication	**MA66**	Missing-incomplete-invalid principal procedure code or date. - Incomplete-invalid principal procedure code and-or date.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
7726	**Medicaid requires documentation for procedures appended with modifier 66 when billing over 3 units of svc. Resubmit as an adj. w/records indicating all surgeons involved this DOS.**	**16**	Claim-service lacks information which is needed for adjudication	**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.
7726	**Medicaid requires documentation for procedures appended with modifier 66 when billing over 3 units of svc. Resubmit as an adj. w/records indicating all surgeons involved this DOS.**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-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.
7726	**Medicaid requires documentation for procedures appended with modifier 66 when billing over 3 units of svc. Resubmit as an adj. w/records indicating all surgeons involved this DOS.**	**16**	Claim-service lacks information which is needed for adjudication	**MA66**	Missing-incomplete-invalid principal procedure code or date. - Incomplete-invalid principal procedure code and-or date.	**294**	Supporting documentation.

7726	**Medicaid requires documentation for procedures appended with modifier 66 when billing over 3 units of svc. Resubmit as an adj. w/records indicating all surgeons involved this DOS.**	**16**	Claim-service lacks information which is needed for adjudication	**N13**	Payment based on professional technical component modifier(s).	**294**	Supporting documentation.
7726	**Medicaid requires documentation for procedures appended with modifier 66 when billing over 3 units of svc. Resubmit as an adj. w/records indicating all surgeons involved this DOS.**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-incomplete-invalid documentation-orders-notes-summary-report-chart	**294**	Supporting documentation.
7726	**Medicaid requires documentation for procedures**	**16**	Claim-service lacks information which is needed for adjudication	**MA66**	Missing-incomplete-invalid principal procedure code or	**453**	Procedure Code Modifier(s) for Service(s) Rendered
					Payment based on professional		

7726	**Medicaid requires documentation for procedures appended with modifier 66 when billing over 3 units of svc. Resubmit as an adj. w/records indicating all surgeons involved this DOS.**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-incomplete-invalid documentation-orders-notes-summary-report-chart	**453**	Procedure Code Modifier(s) for Service(s) Rendered
7727	**Once in a lifetime procedure has been previously completed. subsequent billings are not allowed.**	**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.
7728	**E&M service. Is included in the global package.**	**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.
					between this service-procedure-		

7733	**E&M included in global surgical package same day.**	**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.
7734	**E&M included in global surgical package same day.**	**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.
7735	**E&M included in global surg. Package, Pre-op.**	**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.
7736	**E-M included in global surgical package, pre-op.**	**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.

7737	**E-M and major surgical procedure not allowed for the same date of service.**	**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.
7738	**E-M and major surgical procedure not allowed for the same date of service.**	**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.
7739	**Decision for surgery' has already been paid for this episode of care.**	**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.
7740	**Service is included in global surgery package.**	**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.

7741	**Service is included in global surgery package.**	**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.
7742	**E-M service is included in reimbursement for ventilation management on the same day.**	**97**	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. 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.
7743	**E-M service is included in reimbursement for ventilation management on the same day.**	**97**	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. 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.
7744	**Fee has been adjusted based on calculated amount for verified number of surgeons on surgical team, for this procedure, this date of service per Medicaid guidelines.**	**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	**258**	Days-units for procedure-revenue code.

7744	**Fee has been adjusted based on calculated amount for verified number of surgeons on surgical team, for this procedure, this date of service per Medicaid guidelines.**	**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	**483**	Maximum coverage amount met or exceeded for benefit period.
7747	**Exceeds 1 proc-day 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.
7747	**Exceeds 1 proc-day 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.	**612**	Per Day Limit Amount
7748	**Exceeds 1 proc-month 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.
7748	**Exceeds 1 proc-month 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.
7749	**Exceeds 1 proc-60 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.
7749	**Exceeds 1 proc-60 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.
7750	**Exceeds 1 proc-225 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.

7750	**Exceeds 1 proc-225 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.
7751	**Exceeds 1 proc-270 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.
7751	**Exceeds 1 proc-270 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.
7752	**Exceeds 2 proc-day 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.
7752	**Exceeds 2 proc-day 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.
7752	**Exceeds 2 proc-day 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.	**612**	Per Day Limit Amount
7752	**Exceeds 2 proc-day 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	**612**	Per Day Limit Amount
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.

7755	**Exceeds 3 proc -day 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.
7755	**Exceeds 3 proc -day 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.
7755	**Exceeds 3 proc -day 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.	**612**	Per Day Limit Amount
7755	**Exceeds 3 proc -day 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	**612**	Per Day Limit Amount
7756	**Exceeds 3 proc-3 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.
7756	**Exceeds 3 proc-3 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.
7757	**Exceeds 4 proc-day 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.
7757	**Exceeds 4 proc-day 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.
7757	**Exceeds 4 proc-day 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.	**612**	Per Day Limit Amount

7757	**Exceeds 4 proc-day 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	**612**	Per Day Limit Amount
7758	**Exceeds 5 proc-day 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.
7758	**Exceeds 5 proc-day 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.
7758	**Exceeds 5 proc-day 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.	**612**	Per Day Limit Amount
7758	**Exceeds 5 proc-day 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	**612**	Per Day Limit Amount
7759	**Exceeds 6 proc-day 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.
7759	**Exceeds 6 proc-day 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.
7759	**Exceeds 6 proc-day 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.	**612**	Per Day Limit Amount
7759	**Exceeds 6 proc-day 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	**612**	Per Day Limit Amount

7760	**Exceeds 8 proc-day 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.
7760	**Exceeds 8 proc-day 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.
7760	**Exceeds 8 proc-day 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.	**612**	Per Day Limit Amount
7760	**Exceeds 8 proc-day 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	**612**	Per Day Limit Amount
7761	**Exceeds 9 proc-day 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.
7761	**Exceeds 9 proc-day 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.
7761	**Exceeds 9 proc-day 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.	**612**	Per Day Limit Amount
7761	**Exceeds 9 proc-day 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	**612**	Per Day Limit Amount
7762	**Exceeds 10 proc-day 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.

7762	**Exceeds 10 proc-day 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.
7762	**Exceeds 10 proc-day 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.	**612**	Per Day Limit Amount
7762	**Exceeds 10 proc-day 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	**612**	Per Day Limit Amount
7763	**Exceeds 12 proc-day 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.
7763	**Exceeds 12 proc-day 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.
7763	**Exceeds 12 proc-day 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.	**612**	Per Day Limit Amount
7763	**Exceeds 12 proc-day 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	**612**	Per Day Limit Amount
7764	**Exceeds 14 proc-day 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.
7764	**Exceeds 14 proc-day 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.

7764	**Exceeds 14 proc-day 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.	**612**	Per Day Limit Amount
7764	**Exceeds 14 proc-day 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	**612**	Per Day Limit Amount
7765	**Exceeds 15 proc-day 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.
7765	**Exceeds 15 proc-day 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.
7765	**Exceeds 15 proc-day 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.	**612**	Per Day Limit Amount
7765	**Exceeds 15 proc-day 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	**612**	Per Day Limit Amount
7766	**Exceeds 25 proc-day 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.
7766	**Exceeds 25 proc-day 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.
7766	**Exceeds 25 proc-day 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.	**612**	Per Day Limit Amount

7766	**Exceeds 25 proc-day 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	**612**	Per Day Limit Amount
7767	**Exceeds 40 proc-day 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.
7767	**Exceeds 40 proc-day 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.
7767	**Exceeds 40 proc-day 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.	**612**	Per Day Limit Amount
7767	**Exceeds 40 proc-day 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	**612**	Per Day Limit Amount
7768	**Exceeds 2 proc-day 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.
7768	**Exceeds 2 proc-day 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.
7768	**Exceeds 2 proc-day 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.	**612**	Per Day Limit Amount
7768	**Exceeds 2 proc-day 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	**612**	Per Day Limit Amount

7769	**Exceeds 3 proc-day 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.
7769	**Exceeds 3 proc-day 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.
7769	**Exceeds 3 proc-day 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.	**612**	Per Day Limit Amount
7769	**Exceeds 3 proc-day 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	**612**	Per Day Limit Amount
7770	**Exceeds 4 proc-day 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.
7770	**Exceeds 4 proc-day 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.
7770	**Exceeds 4 proc-day 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.	**612**	Per Day Limit Amount
7770	**Exceeds 4 proc-day 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	**612**	Per Day Limit Amount
7771	**Exceeds 5 proc-day 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.

7771	**Exceeds 5 proc-day 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.
7771	**Exceeds 5 proc-day 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.	**612**	Per Day Limit Amount
7771	**Exceeds 5 proc-day 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	**612**	Per Day Limit Amount
7772	**Exceeds 6 proc day 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.
7772	**Exceeds 6 proc day 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.
7772	**Exceeds 6 proc day 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.	**612**	Per Day Limit Amount
7772	**Exceeds 6 proc day 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	**612**	Per Day Limit Amount
7773	**Exceeds 7 proc-day 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.
7773	**Exceeds 7 proc-day 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.

7773	**Exceeds 7 proc-day 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.	**612**	Per Day Limit Amount
7773	**Exceeds 7 proc-day 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	**612**	Per Day Limit Amount
7774	**Exceeds 15 proc-day 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.
7774	**Exceeds 15 proc-day 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.
7774	**Exceeds 15 proc-day 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.	**612**	Per Day Limit Amount
7774	**Exceeds 15 proc-day 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	**612**	Per Day Limit Amount
7775	**Exceeds 50 proc-day 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.
7775	**Exceeds 50 proc-day 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.
7775	**Exceeds 50 proc-day 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.	**612**	Per Day Limit Amount

7775	**Exceeds 50 proc-day 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	**612**	Per Day Limit Amount
7776	**Exceeds 1 proc-six months limit.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N411**	This service is allowed one time in a 6-month period.	**259**	Frequency of service.
7777	**Exceeds 1 proc-14 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.
7777	**Exceeds 1 proc-14 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.
7778	**Exceeds-30 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.
7778	**Exceeds-30 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.
7779	**Exceeds 1 proc-60 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.
7779	**Exceeds 1 proc-60 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.
7781	**Once in a lifetime procedure has been previously billed as unilateral. Subsequent complete and same location services are not allowed.**	**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.

7782	**Once in a lifetime procedure has been previously billed as unilateral. Subsequent complete and same location services are not allowed.**	**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.
7783	**This surgical procedure previously paid at maximum allowed for primary surgeon. If appropriate, rebill as assistant or file as an adjustment with documentation of multi-surgeons.**	**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.
7783	**This surgical procedure previously paid at maximum allowed for primary surgeon. If appropriate, rebill as assistant or file as an adjustment with documentation of multi-surgeons.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**414**	Need for more than one physician to treat patient.
7784	**This procedure code has been billed as primary surgeon on a separate claim. If appropriate, rebill as assistant or file as an adjustment with documentation of multi-surgeons.**	**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.
7784	**This procedure code has been billed as primary surgeon on a separate claim. If appropriate, rebill as assistant or file as an adjustment with documentation of multi-surgeons.**	**18**	Exact duplicate claim-service	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**414**	Need for more than one physician to treat patient.

7785	**Service has previously been paid as assistant surgeon.**	**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.
7786	**Service has been billed as a co-surgery or a team surgery procedure. Medicaid does not allow an assistant surgeon when the procedure is performed by team or co-surgeons.**	**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.
7787	**Service has previously been paid as team or co-surgery. Medicaid does not allow an assistant surgeon when the procedure was performed by a team or co-surgeons.**	**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.
7788	**Claim has same procedure on multiple details with modifier(s) appended indicating more than one surgeon. Medicaid only allows one attending provider per 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.
7789	**This surgery has previously been submitted as team surgery.**	**18**	Exact duplicate claim-service		**No Mapping Required**	**258**	Days-units for procedure-revenue code.
7790	**This surgery has previously been submitted as a co-surgery.**	**18**	Exact duplicate claim-service		**No Mapping Required**	**258**	Days-units for procedure-revenue code.

7791	**The modifier billed indicates this procedure was conducted as co-surgery already involving two surgeons.**	**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.
7792	**Duplicate billing- same procedure, same provider, same DOS, same or related modifier(s) bilateral.**	**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.
7793	**Complete proc. has been prev. billed. Add'l service in the global period aren't allowed.**	**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.
7794	**Part of the global package for this service has prev been billed. Add'l complete service is not allowed.**	**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.
7796	**Exceeds one-lifetime limit.**	**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.
7797	**Exceeds two per lifetime limitation**	**149**	Lifetime benefit maximum has been reached for this service-benefit category	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.

7798	**E-M included in global surgical package pre-op.**	**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.
7799	**E-M included in global surgical package pre-op.**	**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.
7800	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7800	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.

7801	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7801	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.
7802	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7802	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.

7803	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7803	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.
7804	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7804	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.

7805	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7805	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.
7806	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7806	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.

7807	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7807	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.
7808	**Reimbursement for base endoscopy is included in rate for related endoscopy proc. performed same day. Refer to May 1999 bulletin for listing of base and related codes.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7808	**Reimbursement for base endoscopy is included in rate for related endoscopy proc. performed same day. Refer to May 1999 bulletin for listing of base and related codes.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.

7809	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7809	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.
7810	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7810	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.

7811	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7811	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.
7812	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7812	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.

7813	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7813	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.
7814	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7814	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.

7815	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7815	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.
7816	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7816	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.

7817	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7817	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.
7818	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7818	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.

7819	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7819	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.
7820	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7820	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.

7821	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7821	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.
7822	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7822	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.

7823	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7823	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.
7824	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7824	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.

7825	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7825	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.
7826	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7826	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.

7827	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7827	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.
7828	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7828	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.

7829	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
7829	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed same day.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**454**	Procedure code for services rendered.
7830	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed 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.
7830	**Reimbursement for base endoscopy is included in rate for related endoscopy procedure performed 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7831	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7831	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7832	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.

7832	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7833	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7833	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7834	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7834	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7835	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.

7835	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7836	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7836	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7837	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7837	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7838	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.

7838	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7839	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7839	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7840	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7840	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7841	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.

7841	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7842	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7842	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7843	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7843	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7844	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.

7844	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7845	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7845	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7846	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7846	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7847	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.

7847	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7848	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7848	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7849	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7849	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7850	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.

7850	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7851	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7851	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7852	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7852	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7853	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.

7853	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7854	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7854	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7855	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7855	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7856	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.

7856	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7857	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7857	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7858	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.
7858	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7859	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.

7859	**Base endoscopy procedure is not allowed when related endoscopy procedure is performed on the 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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7860	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7860	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7861	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7861	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7862	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.

7862	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7863	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7863	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7864	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7864	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7865	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.

7865	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7866	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7866	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7867	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7867	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7868	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.

7868	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7869	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7869	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7870	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7870	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7871	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.

7871	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7872	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7872	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7873	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7873	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7874	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.

7874	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7875	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7875	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7876	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7876	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7877	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.

7877	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7878	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7878	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7879	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7879	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7880	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.

7880	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7881	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7881	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7882	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7882	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7883	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.

7883	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7884	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7884	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7885	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7885	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7886	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.

7886	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7887	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7887	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.

7888	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.
7888	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7889	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.

7889	**Multiple endoscopy procedures performed on the same day are reimbursed according to endoscopy pricing calculations set forth by Medicaid guidelines.**	**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.	**N59**	**Alert-** Please refer to your provider manual for additional program and provider information	**258**	Days-units for procedure-revenue code.
7890	**Base proc. has been billed as discontinued. Related procedures are not allowed on the same DOS as the base that has been discontinued.**	**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.
7890	**Base proc. has been billed as discontinued. Related procedures are not allowed on the same DOS as the base that has been discontinued.**	**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.	**N65**	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service-provider.	**258**	Days-units for procedure-revenue code.

7891	**Related procedures are not allowed on the same DOS as the base proc that has been discontinued.**	**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.
7891	**Related procedures are not allowed on the same DOS as the base proc that has been discontinued.**	**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.	**N65**	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service-provider.	**258**	Days-units for procedure-revenue code.
7900	**This service or procedure is included in anesthesia global package.**	**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.

7901	**This service or procedure is included in anesthesia global package.**	**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.
7902	**E&M service is included in anesthesia Global package pre-care day.**	**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.
7903	**E&M service is included in anesth. Global package pre-care day.**	**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.
7904	**No Payment for add-on (zzz) code allowed if “primary” code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7904	**No Payment for add-on (zzz) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7905	**No Payment for add-on (zzz) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7905	**No Payment for add-on (zzz) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7906	**No Payment for add-on (size) code allowed if in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7906	**No Payment for add-on (size) code allowed if in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7907	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7907	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7908	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7908	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7909	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7909	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7910	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7910	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7911	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7911	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7912	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7912	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7913	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7913	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7914	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7914	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7915	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7915	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7916	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7916	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7917	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7917	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7918	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7918	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7919	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7919	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7920	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7920	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7921	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7921	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7922	**No payment allowed if primary procedure code is not paid for the same date of service, same or different provider**	**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.	**454**	Procedure code for services rendered.

7922	**No payment allowed if primary procedure code is not paid for the same date of service, same or different provider**	**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.	**454**	Procedure code for services rendered.
7923	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7923	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7924	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7924	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7925	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7925	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7926	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7926	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7927	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7927	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7928	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7928	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7929	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7929	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7930	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7930	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7931	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7931	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7932	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7932	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7933	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7933	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7934	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7934	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7935	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7935	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7936	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7936	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7937	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7937	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7938	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7938	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7939	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7939	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7940	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7940	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7941	**No Payment for add-on (size) code allowed if primary code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7941	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7942	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7942	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7943	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7943	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7944	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7944	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7945	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7945	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7946	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7946	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7947	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7947	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7948	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7948	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7949	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7949	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7950	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7950	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7951	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7951	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7952	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7952	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7953	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7953	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7954	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7954	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7955	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7955	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7956	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7956	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7957	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7957	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7958	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7958	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7959	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7959	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7960	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7960	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7961	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7961	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7962	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7962	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7963	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7963	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7964	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7964	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7965	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7965	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7966	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7966	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7967	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7967	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7968	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7968	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7969	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7969	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7970	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7970	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7971	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7971	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7972	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7972	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7973	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7973	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7974	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7974	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7975	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7975	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7976	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7976	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7977	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7977	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7978	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7978	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7979	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7979	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7980	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7980	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7981	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7981	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7982	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7982	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7983	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7983	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7984	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7984	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7985	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7985	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7986	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7986	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7987	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7987	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7988	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7988	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7989	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7989	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7990	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7990	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7991	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7991	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7992	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7992	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7993	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7993	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7994	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.

7994	**No Payment for add-on (size) code allowed if "primary" code in series is not paid for the same date of service, same provider.**	**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.	**454**	Procedure code for services rendered.
7995	**Refile as an adjustment with documentation (operative notes, discharge summary) of all surgery procedures performed this provider, this date of servie.**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-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.
7995	**Refile as an adjustment with documentation (operative notes, discharge summary) of all surgery procedures performed this provider, this date of servie.**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-incomplete-invalid documentation-orders-notes-summary-report-chart	**297**	Medical notes-report
7996	**Only one surgical code per day is allowed as the primary procedure. Another code has already been billed a primary for this DOS. Correct detail by appending -51 and rebill.**	**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.
7996	**Only one surgical code per day is allowed as the primary procedure. Another code has already been billed a primary for this DOS. Correct detail by appending -51 and rebill.**	**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
7997	**Only one surgical code per day is allowed as the primary procedure. Another code has already been billed a primary for this DOS. Correct detail by appending -51 and rebill.**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**259**	Frequency of service.

7997	**Only one surgical code per day is allowed as the primary procedure. Another code has already been billed a primary for this DOS. Correct detail by appending -51 and rebill.**	**119**	Benefit maximum for this time period or occurrence has been reached.		**No Mapping Required**	**612**	Per Day Limit Amount
7998	**Evaluation and management services not allowed within the postoperative period of related surgical procedure**	**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.	**258**	Days-units for procedure-revenue code.
7999	**Surgical Procedure's postoperative period includes follow –up E-M 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.
8103	**Covered days and patient status are inconsistent with bill type. Correct your bill type or patient status 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.
8105	**Allowed days for lower level of care in acute facility has been exceeded**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount.

8107	**Therapeutic leave not reimbursable to this provider type when billling lower level of care (LLOC)**	**185**	The rendering provider is not eligible to perform the service billed. Note- Refer to the 835 Healthcare Policy Identificaiton Segment (loop 2110 Service Payment Information REF), if presentNote-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF0, if present	**N95**	This provider type-provider specialty may not bill this service.	**91**	Entity not eligible-not approved for dares of service. Note-This code requires use of an Entiy Code.
8009	**Transition and education services dollar limitation per waiver year has been exceeded**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**483**	Maximum coverage amount met or exceeded for benefit period.
8010	**Non-Telemedicine service not allowed same day as a related Telemedicine service.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
8010	**Non-Telemedicine service not allowed same day as a related Telemedicine service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
8010	**Non-Telemedicine service not allowed same day as a related Telemedicine service.**	**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
8010	**Non-Telemedicine service not allowed same day as a related Telemedicine service.**	**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
8011	**Telemedicine service not allowed same day as a related Non-Telemedicince service.**	**169**	Payment adjusted because an alternate benefit has been provided	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
8011	**Telemedicine service not allowed same day as a related Non-Telemedicince service.**	**169**	Payment adjusted because an alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.

8011	**Telemedicine service not allowed same day as a related Non-Telemedicince service.**	**169**	Payment adjusted because an alternate benefit has been provided	**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
8011	**Telemedicine service not allowed same day as a related Non-Telemedicince service.**	**169**	Payment adjusted because an alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
8012	**Separate E/M procedure not allowed same day as a Telemedicine service.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
8012	**Separate E/M procedure not allowed same day as a Telemedicine service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
8012	**Separate E/M procedure not allowed same day as a Telemedicine service.**	**A1**	Claim-Service denied	**N358**	**Alert-** This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted	**187**	Date(s) of service.
8012	**Separate E/M procedure not allowed same day as a Telemedicine service.**	**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
8012	**Separate E/M procedure not allowed same day as a Telemedicine service.**	**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
8012	**Separate E/M procedure not allowed same day as a Telemedicine service.**	**A1**	Claim-Service denied	**N358**	**Alert-** This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted	**453**	Procedure Code Modifier(s) for Service(s) Rendered
8013	**Telemedicine service not allowed same day as a separate E/M procedure.**	**169**	Payment adjusted because an alternate benefit has been provided	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.

8013	**Telemedicine service not allowed same day as a separate E/M procedure.**	**169**	Payment adjusted because an alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
8013	**Telemedicine service not allowed same day as a separate E/M procedure.**	**169**	Payment adjusted because an alternate benefit has been provided	**N358**	**Alert-** This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted.	**187**	Date(s) of service.
8013	**Telemedicine service not allowed same day as a separate E/M procedure.**	**169**	Payment adjusted because an alternate benefit has been provided	**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
8013	**Telemedicine service not allowed same day as a separate E/M procedure.**	**169**	Payment adjusted because an alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
8013	**Telemedicine service not allowed same day as a separate E/M procedure.**	**169**	Payment adjusted because an alternate benefit has been provided	**N358**	**Alert-** This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
8014	**Standby service not allowed same day as a Telemedicine procedure.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
8014	**Standby service not allowed same day as a Telemedicine procedure.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
8014	**Standby service not allowed same day as a Telemedicine procedure.**	**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
8014	**Standby service not allowed same day as a Telemedicine procedure.**	**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

8015	**Telemedicine service not allowed same day as a standby service.**	**169**	Payment adjusted because an alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
8015	**Telemedicine service not allowed same day as a standby service.**	**169**	Payment adjusted because an alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
8015	**Telemedicine service not allowed same day as a standby service.**	**169**	Payment adjusted because an alternate benefit has been provided.	**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
8015	**Telemedicine service not allowed same day as a standby service.**	**169**	Payment adjusted because an alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
8016	**New patient eye exam one per 3 year limit exceeded**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
8016	**New patient eye exam one per 3 year limit exceeded**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**263**	Length of time for services rendered.
8017	**Diagnostic procedure allowed once per day unless billed with appropriate modifiers**	**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.
8017	**Diagnostic procedure allowed once per day unless billed with appropriate modifiers**	**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.	**263**	Length of time for services rendered.
8018	**Repeat diagnostic procedure allowed twice 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.
8018	**Repeat diagnostic procedure allowed twice 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.	**263**	Length of time for services rendered.

8019	**Assistive technology dollar limitation per lifetime of the waiver has been exceeded**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**483**	Maximum coverage amount met or exceeded for benefit period.
8020	**Procedure is only covered for money follows ther person recipient.**	**A1**	Claim-Service denied	**M51**	Missing-incomplete-invalid procedure code(s).	**454**	Procedure code for services rendered.
8021	**Service Denied. Moderate sedation and anesthesia procedures not allowed same date of service.**	**169**	Payment adjusted because an alternate benefit has been provided	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
8021	**Service Denied. Moderate sedation and anesthesia procedures not allowed same date of service.**	**169**	Payment adjusted because an alternate benefit has been provided	**M86**	Service denied because payment already made for same-similar procedure within set time	**187**	Date(s) of service.
8021	**Service Denied. Moderate sedation and anesthesia procedures not allowed same date of service.**	**169**	Payment adjusted because an alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
8021	**Service Denied. Moderate sedation and anesthesia procedures not allowed same date of service.**	**169**	Payment adjusted because an alternate benefit has been provided	**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
8021	**Service Denied. Moderate sedation and anesthesia procedures not allowed same date of service.**	**169**	Payment adjusted because an alternate benefit has been provided	**M86**	Service denied because payment already made for same-similar procedure within set time	**453**	Procedure Code Modifier(s) for Service(s) Rendered
8021	**Service Denied. Moderate sedation and anesthesia procedures not allowed same date of service.**	**169**	Payment adjusted because an alternate benefit has been provided	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
8022	**Service Denied. Moderate sedation services not allowed on the same date of service as anesthesia related procedures.**	**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.	**187**	Date(s) of service.

8022	**Service Denied. Moderate sedation services not allowed on the same date of service as anesthesia related procedures.**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
8022	**Service Denied. Moderate sedation services not allowed on the same date of service as anesthesia related procedures.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
8022	**Service Denied. Moderate sedation services not allowed on the same date of service as anesthesia related procedures.**	**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.	**259**	Frequency of service.
8022	**Service Denied. Moderate sedation services not allowed on the same date of service as anesthesia related procedures.**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

8022	**Service Denied. Moderate sedation services not allowed on the same date of service as anesthesia related procedures.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
8022	**Service Denied. Moderate sedation services not allowed on the same date of service as anesthesia related procedures.**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
8022	**Service Denied. Moderate sedation services not allowed on the same date of service as anesthesia related procedures.**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
8022	**Service Denied. Moderate sedation services not allowed on the same date of service as anesthesia related procedures.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered

8023	**Anesthesia related procedure not allowed on the same date of service as moderate sedation 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.	**187**	Date(s) of service.
8023	**Anesthesia related procedure not allowed on the same date of service as moderate sedation 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
8023	**Anesthesia related procedure not allowed on the same date of service as moderate sedation 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.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
8023	**Anesthesia related procedure not allowed on the same date of service as moderate sedation 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.	**259**	Frequency of service.

8023	**Anesthesia related procedure not allowed on the same date of service as moderate sedation 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
8023	**Anesthesia related procedure not allowed on the same date of service as moderate sedation 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.	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
8023	**Anesthesia related procedure not allowed on the same date of service as moderate sedation 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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
8023	**Anesthesia related procedure not allowed on the same date of service as moderate sedation 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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered

8023	**Anesthesia related procedure not allowed on the same date of service as moderate sedation 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.	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
8024	**Service denied. Moderate sedation is included in a service already paid to the same or different provider in history. Reference CPT appendix G.**	**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.	**187**	Date(s) of service.
8024	**Service denied. Moderate sedation is included in a service already paid to the same or different provider in history. Reference CPT appendix G.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
8024	**Service denied. Moderate sedation is included in a service already paid to the same or different provider in history. Reference CPT appendix G.**	**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.	**259**	Frequency of service.

8024	**Service denied. Moderate sedation is included in a service already paid to the same or different provider in history. Reference CPT appendix G.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
8024	**Service denied. Moderate sedation is included in a service already paid to the same or different provider in history. Reference CPT appendix G.**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
8024	**Service denied. Moderate sedation is included in a service already paid to the same or different provider in history. Reference CPT appendix G.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
8025	**Moderate sedation recouped to allow payment of service which includes sedation for same date of service. Reference CPT appendix G.**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.

8025	**Moderate sedation recouped to allow payment of service which includes sedation for same date of service. Reference CPT appendix G.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
8025	**Moderate sedation recouped to allow payment of service which includes sedation for same date of service. Reference CPT appendix G.**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
8025	**Moderate sedation recouped to allow payment of service which includes sedation for same date of service. Reference CPT appendix G.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**259**	Frequency of service.
8025	**Moderate sedation recouped to allow payment of service which includes sedation for same date of service. Reference CPT appendix G.**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered

8025	**Moderate sedation recouped to allow payment of service which includes sedation for same date of service. Reference CPT appendix G.**	**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.	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
8026	**Moderate sedation add-on code must be billed with a paid primary procedure for reimbursement.**	**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.	**454**	Procedure code for services rendered.
8027	**Service Denied. E/M service and moderate sedation not allowed same date of service. The same or different provider has been paid for moderate sedation this date.**	**169**	Payment adjusted because an alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
8027	**Service Denied. E/M service and moderate sedation not allowed same date of service. The same or different provider has been paid for moderate sedation this date.**	**169**	Payment adjusted because an alternate benefit has been provided.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
8027	**Service Denied. E/M service and moderate sedation not allowed same date of service. The same or different provider has been paid for moderate sedation this date.**	**169**	Payment adjusted because an alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.

8027	**Service Denied. E/M service and moderate sedation not allowed same date of service. The same or different provider has been paid for moderate sedation this date.**	**169**	Payment adjusted because an alternate benefit has been provided.	**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
8027	**Service Denied. E/M service and moderate sedation not allowed same date of service. The same or different provider has been paid for moderate sedation this date.**	**169**	Payment adjusted because an alternate benefit has been provided.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
8027	**Service Denied. E/M service and moderate sedation not allowed same date of service. The same or different provider has been paid for moderate sedation this date.**	**169**	Payment adjusted because an alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
8028	**Service Denied. Moderate sedation not allowed same date of service as E/M services. Moderate sedation already paid to same or different provider this date.**	**169**	Payment adjusted because an alternate benefit has been provided.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
8028	**Service Denied. Moderate sedation not allowed same date of service as E/M services. Moderate sedation already paid to same or different provider this date.**	**169**	Payment adjusted because an alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
8028	**Service Denied. Moderate sedation not allowed same date of service as E/M services. Moderate sedation already paid to same or different provider this date.**	**169**	Payment adjusted because an alternate benefit has been provided.	**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

8028	**Service Denied. Moderate sedation not allowed same date of service as E/M services. Moderate sedation already paid to same or different provider this date.**	**169**	Payment adjusted because an alternate benefit has been provided.	**N20**	Service not payable with other service rendered on the same date.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
8029	**Claim Denied. Inpatient place of service being billed and recipient is not enrolled in money follows the person (MFP)**	**A1**	Claim-Service denied	**N428**	Service-procedure not covered when performed in this place of service.	**249**	Place of service.
8030	**Money follows the person (MFP) programs of all-inclusive care for the elderly (PACE) dollar limitation for this service has been exceeded**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	**M139**	Denied services exceed the coverage limit for the demonstration.	**483**	Maximum coverage amount met or exceeded for benefit period.
8031	**Procedure is limited to 36 per 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.	**259**	Frequency of service.
8031	**Procedure is limited to 36 per year.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
8031	**Procedure is limited to 36 per 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.
8031	**Procedure is limited to 36 per year.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
8032	**Unit Cutback. Limited to 36 per 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.	**259**	Frequency of service.
8032	**Unit Cutback. Limited to 36 per year.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
8032	**Unit Cutback. Limited to 36 per 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.

8032	**Unit Cutback. Limited to 36 per year.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**483**	Maximum coverage amount met or exceeded for benefit period.
8033	**DOLLAR LIMITATION FOR CAPMR MODIFICATION PROCEDURES BILLED DURING WAIVER PERIOD HAS BEEN EXCEEDED BY THE SAME OR DIFFERENT PROVIDER**	**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.
8036	**MFP-TRANSITION YEAR STABILITY RESOURCE (TYSR) "DEMONSTRATION" SERVICE PROVIDED BY THE SAME OR DIFFERENT PROVIDER HAS EXCEEDED THE APPROVED MAXIMUM DOLLAR LIMITATION PER 365 DAYS**	**96**	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N59**	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.
8036	**MFP-TRANSITION YEAR STABILITY RESOURCE (TYSR) "DEMONSTRATION" SERVICE PROVIDED BY THE SAME OR DIFFERENT PROVIDER HAS EXCEEDED THE APPROVED MAXIMUM DOLLAR LIMITATION PER 365 DAYS**	**96**	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N59**	Please refer to your provider manual for additional program and provider information.	**454**	Procedure code for services rendered.
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.
8051	**Service denied. Exceeds the allowed units per day, same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
8052	**Service denied. Exceeds the allowed units per calendar month, same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
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.
8054	**Service denied. Exceeds the allowed units per year, same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
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.

8073	**CAPMR YEARLY DOLLAR LIMTATION FOR THIS PROCEDURE FOR WAIVER YEAR EXCEEDED BY SAME OR DIFFERENT PROVIDER**	**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.
8074	**BILLED AMOUNT FOR THIS CAPMR PROCEDURE EXCEEDS THE DOLLAR LIMITATION ALLOWED FOR THE WAIVER YEAR. PAYMENT HAS BEEN REDUCED/CUTBACK TO THE ALLOWED LIMIT**	**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.
							This change effective 7-1-2011-

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.
8111	**Dollar amount cutback to the allowable maximum for money**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-	**M139**	Denied services exceed the coverage limit for the	**483**	Maximum coverage amount met or exceeded for benefit

8131	**Service not allowed greater than 60 days for MFP / PACE transitioning recipient**	**A1**	Claim-Service denied	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**585**	Denied Charge or Non-covered Charge
8171	**Vaccine limited to one per day same or different provider**	**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.
8173	**Coordination fees and management fees are reimbursed through system-generated claims only.**	**125**	Submission-billing error(s)	**N185**	**Alert-** Do not resubmit this claim-service	**107**	Processed according to contract-plan provisions.
8173	**Coordination fees and management fees are reimbursed through system-generated claims only.**	**125**	Submission-billing error(s)	**N185**	**Alert-** Do not resubmit this claim-service	**551**	Coordination of Benefits Total Submitted Charge
8174	**Sick visit codes may not be billed on the same claim form as Health Check screening services.**	**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.	**N61**	Rebill services on separate claims.	**258**	Days-units for procedure-revenue code.
8175	**All other dates of service must be billed on a separate claim form from Health Check screening dates of service.**	**125**	Submission-billing error(s)	**N61**	Rebill services on separate claims.	**481**	Claim-submission format is invalid.
8202	**Procedure exceeds limit of one unit per 365 days for the same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
8203	**Procedure exceeds limit of one time per calendar year for the same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

8204	**Only two units of the related imaging procedures in any combination allowed per 365 days with this diagnosis for the same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
8301	**Units cutback to the maximum allowed units per day by same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
8301	**Units cutback to the maximum allowed units per day by same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**612**	Per Day Limit Amount
8311	**Units cutback to the maximum allowed units per calendar month by same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
8311	**Units cutback to the maximum allowed units per calendar month by same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service
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.
8399	**Hospice Patient. Contact Hospice responsible for patient's care. Non-Hospice services(s) recouped, re-file claim only for date(s) of service not covered by hospice benefit.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

8399	**Hospice Patient. Contact Hospice responsible for patient's care. Non-Hospice services(s) recouped, re-file claim only for date(s) of service not covered by hospice benefit.**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**259**	Frequency of service.
8399	**Hospice Patient. Contact Hospice responsible for patient's care. Non-Hospice services(s) recouped, re-file claim only for date(s) of service not covered by hospice benefit.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**454**	Procedure code for services rendered.
8399	**Hospice Patient. Contact Hospice responsible for patient's care. Non-Hospice services(s) recouped, re-file claim only for date(s) of service not covered by hospice benefit.**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met	**454**	Procedure code for services rendered.
8400	**Hospice Pt. Contact Hospice resp. For Pt's care. Refile claim only for DOS not covered by Hospice-refile claim w-Medicare for DOS not cov.by Hospice.**	**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.	**457**	Non-Covered Day(s)
8400	**Hospice Pt. Contact Hospice resp. For Pt's care. Refile claim only for DOS not covered by Hospice-refile claim w-Medicare for DOS not cov.by Hospice.**	**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.	**457**	Non-Covered Day(s)

8401	**Hospice Pt. Contact Hospice resp. For Pt's care. Refile claim only for DOS not covered by Hospice-refile claim w-Medicare for DOS not cov.by Hospice.**	**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.	**457**	Non-Covered Day(s)
8401	**Hospice Pt. Contact Hospice resp. For Pt's care. Refile claim only for DOS not covered by Hospice-refile claim w-Medicare for DOS not cov.by Hospice.**	**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.	**457**	Non-Covered Day(s)
8406	**Hospice Patient. Contact Hospice Responsible for patient's care. Refile claim only for date(s) of service not covered by hospice benefit.**	**A1**	Claim-Service denied	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
8406	**Hospice Patient. Contact Hospice Responsible for**	**A1**	Claim-Service denied	**N357**	Time frame requirements between this service-procedure-	**259**	Frequency of service.
					between this service-procedure-		

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.
8498	**DME IOU code units cutback to maximum units allowed per calendar month for the same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of days or units of service exceeds our acceptable maximum.	**259**	Frequency of Service.
8499	**DME IOU code units exceed maximum allowed units per calendar month for the same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of days or units of service exceeds our acceptable maximum.	**259**	Frequency of Service.
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 documenation.**	**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 documenation.**	**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 documenation.**	**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.
8703	**Override limit exceeded. Prescriber call ACS 866-246-8505**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M86**	**Service denied because payment already made for same-similar procedure within set time frame.**	**294**	Supporting documentation. Note: At least one other status code is required to identify the supporting documentation.
8703	**Override limit exceeded. Prescriber call ACS 866-246-8505**	**B5**	Coverage-program guidelines were not met or were exceeded.	**M86**	**Service denied because payment already made for same-similar procedure within set time frame.**	**297**	Medical notes-report.

8704	**M/I PATIENT RESIDENCE**	**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.
8705	**Follow-up care is included in radiation management**	**97**	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
8706	**Services recouped. Radiation management paid in follow-up care**	**97**	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
8710	**M/I MEDICAID INDICATOR**	**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.
8711	**PA TYPE CODE NOT SUPPORTED**	**125**	Submission-billing error(s)	**M79**	Missing-incomplete-invalid charge.	**585**	Denied Charge or Non-covered Charge
8712	**SUBMISSION CLARIFICATION NOT SUPPORTED**	**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.
8714	**DIAGNOSIS CODE QUALIFIER NOT SUPPORTED**	**146**	Diagnosis was invalid for the dates of service reported.	**M76**	Missing-incomplete-invalid diagnosis or condition.	**255**	Diagnosis code.
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

8901	**CLAIM MUST BE ACCOMPANIED BY AN ABORTION STATEMENT. RESUBMIT THE CLAIM WITH ABORTION STATEMENT ATTACHED**	**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.
8901	**CLAIM MUST BE ACCOMPANIED BY AN ABORTION STATEMENT. RESUBMIT THE CLAIM WITH ABORTION STATEMENT ATTACHED**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes- summary- report- chart	**291**	Reason for termination of pregnancy.
8901	**CLAIM MUST BE ACCOMPANIED BY AN ABORTION STATEMENT. RESUBMIT THE CLAIM WITH ABORTION STATEMENT ATTACHED**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes- summary- report- chart	**297**	Medical notes-report.
8902	**GESTATIONAL AGE MUST APPEAR ON THE ABORTION STATEMENT. PLEASE COMPLETE THE ABORTION STATEMENT BY ADDING THE GESTATIONAL AGE AND RESUBMIT WITH CLAIM AND OR RECORDS**	**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.
8902	**GESTATIONAL AGE MUST APPEAR ON THE ABORTION STATEMENT. PLEASE COMPLETE THE ABORTION STATEMENT BY ADDING THE GESTATIONAL AGE AND RESUBMIT WITH CLAIM AND OR RECORDS**	**16**	Claim-service lacks information which is needed for adjudication	**N225**	Incomplete-invalid documentation-orders- notes-summary- report- chart	**297**	Medical notes/report.
8903	**Claim denied; Rape and incest abortions not allowed for gestational age beyond 20 weeks.**	**16**	Claim-service lacks information which is needed for adjudication	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**258**	Days-units for procedure-revenue code.

8903	**Claim denied; Rape and incest abortions not allowed for gestational age beyond 20 weeks.**	**16**	Claim-service lacks information which is needed for adjudication	**N115**	This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD). An LMRP-LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http--- www.cms.hhs.gov-mcd, or if you do not have web access, you may contact the contractor to request a copy of the LMRP-LCD	**258**	Days-units for procedure-revenue code.
8904	**ABORTION CLAIM FOR INCEST MUST SHOW DIAGNOSIS OF V618 ONLY. REMOVE THERAPEUTIC ABORTION DIAGNOSIS AND RESUBMIT CLAIM**	**125**	Submission-billing error(s)	**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.
8904	**ABORTION CLAIM FOR INCEST MUST SHOW DIAGNOSIS OF V618 ONLY. REMOVE THERAPEUTIC ABORTION DIAGNOSIS AND RESUBMIT CLAIM**	**125**	Submission-billing error(s)	**N29**	Missing documentation-orders-notes- summary- report- chart	**297**	Medical notes/report.
8904	**ABORTION CLAIM FOR INCEST MUST SHOW DIAGNOSIS OF V618 ONLY. REMOVE THERAPEUTIC ABORTION DIAGNOSIS AND RESUBMIT CLAIM**	**125**	Submission-billing error(s)	**N29**	Missing documentation-orders-notes- summary- report- chart	**488**	Diagnosis code(s) for the services rendered.

8905	**LEGAL GUARDIAN MUST SIGN ABORTION STATEMENT IF RECIPIENT IS MENTALLY INCOMPETENT OR INSTITUTIONALIZED. PLEASE OBTAIN SIGNATURE AND RESUBMIT WITH CLAIM AND RECORDS**	**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.
8905	**LEGAL GUARDIAN MUST SIGN ABORTION STATEMENT IF RECIPIENT IS MENTALLY INCOMPETENT OR INSTITUTIONALIZED. PLEASE OBTAIN SIGNATURE AND RESUBMIT WITH CLAIM AND RECORDS**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing documentation-orders-notes- summary- report- chart	**297**	Medical notes/report.
8906	**ABORTION CLAIM FOR RAPE MUST SHOW DIAGNOSIS OF V715 ONLY. REMOVE THERAPEUTIC ABORTION DIAGNOSIS AND RESUBMIT CLAIM**	**125**	Submission-billing error(s)	**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.
8906	**ABORTION CLAIM FOR RAPE MUST SHOW DIAGNOSIS OF V715 ONLY. REMOVE THERAPEUTIC ABORTION DIAGNOSIS AND RESUBMIT CLAIM**	**125**	Submission-billing error(s)	**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.
8906	**ABORTION CLAIM FOR RAPE MUST SHOW DIAGNOSIS OF V715 ONLY. REMOVE THERAPEUTIC ABORTION DIAGNOSIS AND RESUBMIT CLAIM**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**297**	Medical notes/report.

8906	**ABORTION CLAIM FOR RAPE MUST SHOW DIAGNOSIS OF V715 ONLY. REMOVE THERAPEUTIC ABORTION DIAGNOSIS AND RESUBMIT CLAIM**	**125**	Submission-billing error(s)	**N29**	Missing documentation-orders-notes- summary- report-chart	**297**	Medical notes/report.
8906	**ABORTION CLAIM FOR RAPE MUST SHOW DIAGNOSIS OF V715 ONLY. REMOVE THERAPEUTIC ABORTION DIAGNOSIS AND RESUBMIT CLAIM**	**125**	Submission-billing error(s)	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered
8906	**ABORTION CLAIM FOR RAPE MUST SHOW DIAGNOSIS OF V715 ONLY. REMOVE THERAPEUTIC ABORTION DIAGNOSIS AND RESUBMIT CLAIM**	**125**	Submission-billing error(s)	**N29**	Missing documentation-orders-notes- summary- report-chart	**488**	Diagnosis code(s) for the services rendered
8907	**Service denied. Only one unit of mental health/substance abuse targeted case management per calendar week allowed for same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
8907	**Service denied. Only one unit of mental health/substance abuse targeted case management per calendar week allowed for same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
8907	**Service denied. Only one unit of mental health/substance abuse targeted case management per calendar week allowed for same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.

8907	**Service denied. Only one unit of mental health/substance abuse targeted case management per calendar week allowed for same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
8908	**Maximum allowed units per day have been exceeded for behavioral health services by same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
8908	**Maximum allowed units per day have been exceeded for behavioral health services by same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**612**	Per Day Limit Amount
8909	**Reason for abortion noted on statement does match the abortion diagnosis noted on claim. Correct and resubmit the claim and statement.**	**16**	Claim-service lacks information which is needed for adjudication	**M76**	Missing-incomplete-invalid diagnosis or condition.	**291**	Reason for termination of pregnancy.
8909	**Reason for abortion noted on statement does match the abortion diagnosis noted on claim. Correct and resubmit the claim and statement.**	**16**	Claim-service lacks information which is needed for adjudication	**N225**	Incomplete-invalid documentation-orders- notes-summary- report- chart	**291**	Reason for termination of pregnancy.
8909	**Reason for abortion noted on statement does match the abortion diagnosis noted on claim. Correct and resubmit the claim and statement.**	**16**	Claim-service lacks information which is needed for adjudication	**M76**	Missing-incomplete-invalid diagnosis or condition.	**421**	Medical review attachment-information for service(s).
8909	**Reason for abortion noted on statement does match the abortion diagnosis noted on claim. Correct and resubmit the claim and statement.**	**16**	Claim-service lacks information which is needed for adjudication	**N225**	Incomplete-invalid documentation-orders- notes-summary- report- chart	**421**	Medical review attachment-information for service(s).

8909	**Reason for abortion noted on statement does match the abortion diagnosis noted on claim. Correct and resubmit the claim and statement.**	**16**	Claim-service lacks information which is needed for adjudication	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.
8909	**Reason for abortion noted on statement does match the abortion diagnosis noted on claim. Correct and resubmit the claim and statement.**	**16**	Claim-service lacks information which is needed for adjudication	**N225**	Incomplete-invalid documentation-orders- notes-summary- report- chart	**488**	Diagnosis code(s) for the services rendered.
8911	**Exceed Maximum Allowed Specialized Therapy Evaluations per Calendar Year, same or different Provider**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
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
8989	**NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
8989	**NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**N142**	The original claim was denied. Resubmit a new claim, not a replacement claim	**218**	NDC number.
8990	**First NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
8990	**First NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**N142**	The original claim was denied. Resubmit a new claim, not a replacement claim	**218**	NDC number.
8991	**Second NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
8991	**Second NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**N142**	The original claim was denied. Resubmit a new claim, not a replacement claim	**218**	NDC number.
8992	**Third NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.

8992	**Third NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**N142**	The original claim was denied. Resubmit a new claim, not a replacement claim	**218**	NDC number.
8993	**Fourth NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
8993	**Fourth NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**N142**	The original claim was denied. Resubmit a new claim, not a replacement claim	**218**	NDC number.
8994	**Fifth NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
8994	**Fifth NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**N142**	The original claim was denied. Resubmit a new claim, not a replacement claim	**218**	NDC number.
8995	**Sixth NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
8995	**Sixth NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**N142**	The original claim was denied. Resubmit a new claim, not a replacement claim	**218**	NDC number.
8996	**Seventh NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
8996	**Seventh NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**N142**	The original claim was denied. Resubmit a new claim, not a replacement claim	**218**	NDC number.
8997	**Eighth NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
8997	**Eighth NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**N142**	The original claim was denied. Resubmit a new claim, not a replacement claim	**218**	NDC number.
8998	**Ninth NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.

8998	**Ninth NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**N142**	The original claim was denied. Resubmit a new claim, not a replacement claim	**218**	NDC number.
8999	**Tenth NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
8999	**Tenth NDC invalid. Verify and enter the correct NDC and submit as a new claim.**	**A1**	Claim-Service denied	**N142**	The original claim was denied. Resubmit a new claim, not a replacement claim	**218**	NDC number.
9000	**DME armrests limited to two per date of service.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
9000	**DME armrests limited to two per**	**119**	Benefit maximum for this time	**N357**	Time frame requirements	**259**	Frequency of service.
					between this service-procedure-		

9007	**Units cutback. Maximum number of units has been exceeded for this service**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service
9007	**Units cutback. Maximum number of units has been exceeded for this service**	**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
9010	**This orthotic or prosthetic code is only allowed for ages 021-115 for dates of service on or after August 1, 2005**	**A1**	Claim-Service denied	**M56**	Procedure code billed is not correct-valid for the services billed or the date of service billed.	**91**	Entity not eligible-not approved for dates of service.
9010	**This orthotic or prosthetic code is only allowed for ages 021-115 for dates of service on or after August 1, 2005**	**A1**	Claim-Service denied	**N302**	Missing-incomplete-invalid other procedure date(s).	**91**	Entity not eligible-not approved for dates of service.
9010	**This orthotic or prosthetic code is only allowed for ages 021-115 for dates of service on or after August 1, 2005**	**A1**	Claim-Service denied	**M56**	Procedure code billed is not correct-valid for the services billed or the date of service billed.	**475**	Procedure code not valid for patient age
9010	**This orthotic or prosthetic code is only allowed for ages 021-115 for dates of service on or after August 1, 2005**	**A1**	Claim-Service denied	**N302**	Missing-incomplete-invalid other procedure date(s).	**475**	Procedure code not valid for patient age
9011	**NDC was terminated for the detail date of service billed**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
9012	**First NDC was terminated for the detail date of service billed**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
9013	**Second NDC was terminated for the detail date of service billed**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
9014	**Third NDC was terminated for the detail date of service billed**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.

9015	**Fourth NDC was terminated for the detail date of service billed**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
9016	**Fifth NDC was terminated for the detail date of service billed**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
9017	**Sixth NDC was terminated for the detail date of service billed**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
9018	**Seventh NDC was terminated for the detail date of service billed**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
9019	**Eighth NDC was terminated for the detail date of service billed**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
9020	**Ninth NDC was terminated for the detail date of service billed**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
9021	**Tenth NDC was terminated for the detail date of service billed**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
9036	**Thank you for reporting this vaccine to our database. In the future, when reporting this vaccine please use the new hepatitis b codes 90744-90747. Code 90731 is discontinued.**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	**M41**	We do not pay for this as the patient has no legal obligation to pay for this.	**15**	One or more originally submitted procedure code have been modified.
9036	**Thank you for reporting this vaccine to our database. In the future, when reporting this vaccine please use the new hepatitis b codes 90744-90747. Code 90731 is discontinued.**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	**M41**	We do not pay for this as the patient has no legal obligation to pay for this.	**19**	Entity acknowledges receipt of claim-encounter
9039	**Only one nurse in-home visit allowed per DOS.**	**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.
9039	**Only one nurse in-home visit allowed per DOS.**	**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

9040	**Revenue code requires HCPCS: Q4055 for DOS 9-1-05-12-31-05, J0886 for DOS 01-01-2006-3-31-2007 & Q4081 for DOS 04-01-2007 forward**	**A1**	Claim-Service denied	**M20**	Missing-incomplete-invalid HCPCS.	**123**	Additional information requested from entity.
9040	**Revenue code requires HCPCS: Q4055 for DOS 9-1-05-12-31-05, J0886 for DOS 01-01-2006-3-31-2007 & Q4081 for DOS 04-01-2007 forward**	**A1**	Claim-Service denied	**M20**	Missing-incomplete-invalid HCPCS.	**455**	Revenue code for services rendered.
9040	**Revenue code requires HCPCS: Q4055 for DOS 9-1-05-12-31-05, J0886 for DOS 01-01-2006-3-31-2007 & Q4081 for DOS 04-01-2007 forward**	**A1**	Claim-Service denied	**M20**	Missing-incomplete-invalid HCPCS.	**507**	HCPCS
9041	**Revenue code requires Value Code 68 in addition to Value Code 48 or 49. Correct-add necessary value code(s) and resubmit as a new day claim**	**A1**	Claim-Service denied	**M49**	Missing-incomplete-invalid value code(s) or amount(s).	**726**	NUBC Value Code Amount(s)
9042	**Disenfranchised resident is not eligible for ACH-PC coverage.**	**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.
9043	**Each 1,000 units of Epogen equals 1 Medicaid unit. Medicaid units for this procedure must be 10 or greater. Correct procedure or units and resubmit as a new day claim**	**A1**	Claim-Service denied	**M53**	Missing-incomplete-invalid days or units of service.	**258**	Days-units for procedure-revenue code.
9043	**Each 1,000 units of Epogen equals 1 Medicaid unit. Medicaid units for this procedure must be 10 or greater. Correct procedure or units and resubmit as a new day claim**	**A1**	Claim-Service denied	**M53**	Missing-incomplete-invalid days or units of service.	**476**	Missing or invalid units of service

9044	**Dates of service for procedure billed must not span multiple months. Separate details according to month(s) and resubmit**	**A1**	Claim-Service denied	**MA31**	Missing-incomplete-invalid beginning and ending dates of the period billed.	**188**	Statement from-through dates.
9044	**Dates of service for procedure billed must not span multiple months. Separate details according to month(s) and resubmit**	**A1**	Claim-Service denied	**N74**	Resubmit with multiple claims, each claim covering services provided in only one calendar month.	**188**	Statement from-through dates.
9053	**Code limited to addition of antibiotics and steroids through existing IV line.**	**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	**N192**	Procedure code incidental to primary procedure.	**454**	Procedure code for services rendered.
9053	**Code limited to addition of antibiotics and steroids through existing IV line.**	**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.	**454**	Procedure code for services rendered.
9054	**Technical component performed by the facility. Rebill as interpretation only.**	**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.

9054	**Technical component performed by the facility. Rebill as interpretation only.**	**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.	**N194**	Technical component not paid if provider does not own the equipment used.	**454**	Procedure code for services rendered.
9054	**Technical component performed by the facility. Rebill as interpretation only.**	**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.	**N200**	The professional component must be billed separately.	**454**	Procedure code for services rendered.
9062	**Claim denied. Exceeds maximum units 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.
9062	**Claim denied. Exceeds maximum units 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
9070	**Intraoral periapical film-complete series not allowed same DOS ,same Provider.**	**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.

9071	**Intraoral Periapical film-complete series not allowed same DOS, same Provider.**	**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.
9074	**Enhanced service not allowd same day as other enhaned mental health service.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
9074	**Enhanced service not allowd same day as other enhaned mental health service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
9074	**Enhanced service not allowd same day as other enhaned mental health service.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
9074	**Enhanced service not allowd same day as other enhaned mental health service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
9075	**Exceeds the maximum 4 units allowed per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
9075	**Exceeds the maximum 4 units allowed per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code.
9075	**Exceeds the maximum 4 units allowed per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
9075	**Exceeds the maximum 4 units allowed per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.

9076	**Exceeds the maximum 1 unit (1 day) per date of service**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
9076	**Exceeds the maximum 1 unit (1 day) per date of service**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code.
9076	**Exceeds the maximum 1 unit (1 day) per date of service**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
9076	**Exceeds the maximum 1 unit (1 day) per date of service**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
9077	**Units cutback to allow the maximum of 4 units per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**258**	Days-units for procedure-revenue code.
9077	**Units cutback to allow the maximum of 4 units per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**258**	Days-units for procedure-revenue code.
9077	**Units cutback to allow the maximum of 4 units per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
9077	**Units cutback to allow the maximum of 4 units per calendar month.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service.
9078	**Enhanced benefit service not allowed same day as other enhanced mental health service**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
9078	**Enhanced benefit service not allowed same day as other enhanced mental health service**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
9078	**Enhanced benefit service not allowed same day as other enhanced mental health service**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.

9078	**Enhanced benefit service not allowed same day as other enhanced mental health service**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
9079	**Enhanced benefit service not allowed same date of service with other periodic mental health service.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
9079	**Enhanced benefit service not allowed same date of service with other periodic mental health service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
9079	**Enhanced benefit service not allowed same date of service with other periodic mental health service.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
9079	**Enhanced benefit service not allowed same date of service with other periodic mental health service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
9080	**Enhanced benefit service not allowed same day as inpatient service paid to a mental health/psychiatric facility.**	**A1**	Claim-Service denied	**MA133**	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	**187**	Date(s) of service.
9080	**Enhanced benefit service not allowed same day as inpatient service paid to a mental health/psychiatric facility.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
9080	**Enhanced benefit service not allowed same day as inpatient service paid to a mental health/psychiatric facility.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
9080	**Enhanced benefit service not allowed same day as inpatient service paid to a mental health/psychiatric facility.**	**A1**	Claim-Service denied	**MA133**	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	**454**	Procedure code for services rendered.

9080	**Enhanced benefit service not allowed same day as inpatient service paid to a mental health/psychiatric facility.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
9080	**Enhanced benefit service not allowed same day as inpatient service paid to a mental health/psychiatric facility.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
9082	**Enhanced benefit service not allowed same day as other enhanced mental health service**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
9082	**Enhanced benefit service not allowed same day as other enhanced mental health service**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
9082	**Enhanced benefit service not allowed same day as other enhanced mental health service**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
9082	**Enhanced benefit service not allowed same day as other enhanced mental health service**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
9083	**Enhanced service not allowed same day as Psch resident treatment facility service.**	**A1**	Claim-Service denied	**MA133**	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	**187**	Date(s) of service.
9083	**Enhanced service not allowed same day as Psch resident treatment facility service.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
9083	**Enhanced service not allowed same day as Psch resident treatment facility service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.

9083	**Enhanced service not allowed same day as Psch resident treatment facility service.**	**A1**	Claim-Service denied	**MA133**	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	**454**	Procedure code for services rendered.
9083	**Enhanced service not allowed same day as Psch resident treatment facility service.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
9083	**Enhanced service not allowed same day as Psch resident treatment facility service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
9084	**Enhanced service not allowed same date of service as inpatient hospital service.**	**A1**	Claim-Service denied	**MA133**	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	**187**	Date(s) of service.
9084	**Enhanced service not allowed same date of service as inpatient hospital service.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**187**	Date(s) of service.
9084	**Enhanced service not allowed same date of service as inpatient hospital service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**187**	Date(s) of service.
9084	**Enhanced service not allowed same date of service as inpatient hospital service.**	**A1**	Claim-Service denied	**MA133**	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	**454**	Procedure code for services rendered.
9084	**Enhanced service not allowed same date of service as inpatient hospital service.**	**A1**	Claim-Service denied	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**454**	Procedure code for services rendered.
9084	**Enhanced service not allowed same date of service as inpatient hospital service.**	**A1**	Claim-Service denied	**N20**	Service not payable with other service rendered on the same date.	**454**	Procedure code for services rendered.
9085	**Claim submitted more than two years after the drug obsolete date is denied.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N182**	This claim-service must be billed according to the schedule for this plan.	**216**	Drug information.

9085	**Claim submitted more than two years after the drug obsolete date is denied.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N182**	This claim-service must be billed according to the schedule for this plan.	**275**	Claim
9085	**Claim submitted more than two years after the drug obsolete date is denied.**	**B5**	Coverage-program guidelines were not met or were exceeded.	**N182**	This claim-service must be billed according to the schedule for this plan.	**718**	Claim-service not submitted within the required timeframe (timely filing).
9086	**Units cutback to allow the maximum of 480 units per calendar year.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
9086	**Units cutback to allow the maximum of 480 units per calendar year.**	**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.
9086	**Units cutback to allow the maximum of 480 units per calendar year.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
9086	**Units cutback to allow the maximum of 480 units per calendar year.**	**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.
9086	**Units cutback to allow the maximum of 480 units per calendar year.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**476**	Missing or invalid units of service
9086	**Units cutback to allow the maximum of 480 units per calendar year.**	**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.	**476**	Missing or invalid units of service
9087	**The drug class of the submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**216**	Drug information.
9087	**The drug class of the submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**218**	NDC number.

9088	**The drug class of the first submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**216**	Drug information.
9088	**The drug class of the first submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**218**	NDC number.
9089	**The drug class of the second submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**216**	Drug information.
9089	**The drug class of the second submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**218**	NDC number.
9090	**The drug class of the third submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**216**	Drug information.

9090	**The drug class of the third submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**218**	NDC number.
9091	**The drug class of the fourth submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**216**	Drug information.
9091	**The drug class of the fourth submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**218**	NDC number.
9092	**The drug class of the fifth submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**216**	Drug information.
9092	**The drug class of the fifth submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**218**	NDC number.

9093	**The drug class of the sixth submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**216**	Drug information.
9093	**The drug class of the sixth submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**218**	NDC number.
9094	**The drug class of the seventh submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**216**	Drug information.
9094	**The drug class of the seventh submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**218**	NDC number.
9095	**The drug class of the eigth submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**216**	Drug information.

9095	**The drug class of the eigth submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**218**	NDC number.
9096	**The drug class of the ninth submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**216**	Drug information.
9096	**The drug class of the ninth submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**218**	NDC number.
9097	**The drug class of the tenth submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**216**	Drug information.
9097	**The drug class of the tenth submitted NDC must match the drug class of the submitted HCPCS drug code.**	**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.	**218**	NDC number.

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.
9099	**Claim denied. Target Case Management - Early Intervention (T1017 HI) is limited to $6000.00 in services per year. This dollar limitation has been exceeded**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**483**	Maximum coverage amount met or exceeded for benefit period.
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
9100	**Payment has been made to an Independent Laboratory, as result payment to you has been recouped.**	**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.

9101	**Due date on consent is invalid. Resubmit claim as an adjustment with consent and documentation verifying "Estimated Date Of Confinement"**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing-incomplete-invalid consent form.	**294**	Supporting documentation
9101	**Due date on consent is invalid. Resubmit claim as an adjustment with consent and documentation verifying "Estimated Date Of Confinement"**	**16**	Claim-service lacks information which is needed for adjudication	**N225**	Incomplete-invalid documentation-orders- notes-summary- report- chart	**294**	Supporting documentation
9101	**Due date on consent is invalid. Resubmit claim as an adjustment with consent and documentation verifying "Estimated Date Of Confinement"**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing-incomplete-invalid consent form.	**492**	Other Procedure Date
9101	**Due date on consent is invalid. Resubmit claim as an adjustment with consent and documentation verifying "Estimated Date Of Confinement"**	**16**	Claim-service lacks information which is needed for adjudication	**N225**	Incomplete-invalid documentation-orders- notes-summary- report- chart	**492**	Other Procedure Date
9102	**Diagnosis and procedure do not match, correct diagnosis and/or procedure code and resubmit claim.**	**11**	The diagnosis is inconsistent with the procedure.	**M76**	Missing-incomplete-invalid diagnosis or condition.	**454**	Procedure code for services rendered.
9102	**Diagnosis and procedure do not match, correct diagnosis and/or procedure code and resubmit claim.**	**11**	The diagnosis is inconsistent with the procedure.	**MA66**	Missing-incomplete-invalid principal procedure code or date.	**454**	Procedure code for services rendered.
9102	**Diagnosis and procedure do not match, correct diagnosis and/or procedure code and resubmit claim.**	**11**	The diagnosis is inconsistent with the procedure.	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered

9102	**Diagnosis and procedure do not match, correct diagnosis and/or procedure code and resubmit claim.**	**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
9103	**Claim recouped. Monthly review indicates providers(s) have billed procedure code(s) inconsistently. Correct code and/or resubmit as an adjustment with records.**	**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.
9104	**Claim recouped. Correct DOS resubmit as new claim and/or resubmit with records as an adjustment verifying DOS**	**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.
9105	**THERE IS NOT A VALID CONSENT/STATEMENT ON FILE. RESUBMIT A VALID CONSENT/STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing-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.
9105	**THERE IS NOT A VALID CONSENT/STATEMENT ON FILE. RESUBMIT A VALID CONSENT/STATEMENT**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing-incomplete-invalid consent form.	**297**	Medical notes/report.
9106	**CONSENT/STATEMENT DOES NOT MEET FEDERAL REQUIREMENTS**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing-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.
9106	**CONSENT/STATEMENT DOES NOT MEET FEDERAL REQUIREMENTS**	**16**	Claim-service lacks information which is needed for adjudication	**N3**	Missing-incomplete-invalid consent form.	**297**	Mediical notes/report.

9107	**Full recoup, visual aids must be billed with a refractive diagnosis as your primary diagnosis.**	**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.
9107	**Full recoup, visual aids must be billed with a refractive diagnosis as your primary diagnosis.**	**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.	**488**	Diagnosis code(s) for the services rendered.
9108	**Units cutback to allow the maximum of 1 unit per day**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**258**	Days-units for procedure-revenue code.
9108	**Units cutback to allow the maximum of 1 unit per day**	**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.
9108	**Units cutback to allow the maximum of 1 unit per day**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
9108	**Units cutback to allow the maximum of 1 unit per day**	**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.
9108	**Units cutback to allow the maximum of 1 unit per day**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**476**	Missing or invalid units of service
9108	**Units cutback to allow the maximum of 1 unit per day**	**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.	**476**	Missing or invalid units of service

9111	**Submit meters with bin #610524. For assistance call 1-800-657-7613**	**125**	Submission-billing errors. 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	**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
					between this service-procedure-		

9133	**Claim denied. Procedure limited to one occurrence per 84 day 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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
9133	**Claim denied. Procedure limited**	**119**	Benefit maximum for this time	**N357**	Time frame requirements between this service-procedure-	**453**	Procedure Code Modifier(s) for

9143	**Procedure must be billed with FP modifier**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
9143	**Procedure must be billed with FP modifier**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing	**M51**	Missing-incomplete-invalid procedure code(s).	**453**	Procedure Code Modifier(s) for Service(s) Rendered
9143	**Procedure must be billed with FP modifier**	**4**	The procedure code is inconsistent with the modifier used or a required modifier is missing	**N142**	The original claim was denied. Resubmit a new claim, not a replacement claim	**453**	Procedure Code Modifier(s) for Service(s) Rendered
9144	**Claim denied. Exceeds maximum units allowed per 90 day limitation**	**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.
9144	**Claim denied. Exceeds maximum units allowed per 90 day 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	**258**	Days-units for procedure-revenue code.
9144	**Claim denied. Exceeds maximum units allowed per 90 day limitation**	**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
9144	**Claim denied. Exceeds maximum units allowed per 90 day 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
9145	**Procedure code covers both axillae, only one unit can be approved**	**A1**	Claim-Service denied	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**476**	Missing or invalid units of service.
9145	**Procedure code covers both axillae, only one unit can be approved**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**476**	Missing or invalid units of service.
9145	**Procedure code covers both axillae, only one unit can be approved**	**A1**	Claim-Service denied	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**612**	Per Day Limit Amount
9145	**Procedure code covers both axillae, only one unit can be approved**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**612**	Per Day Limit Amount

9147	**Claim denied. E&M procedure not allowed same DOS as Administration procedure**	**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.	**187**	Date(s) of service.
9147	**Claim denied. E&M procedure not allowed same DOS as Administration procedure**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**187**	Date(s) of service.
9147	**Claim denied. E&M procedure not allowed same DOS as Administration procedure**	**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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.
9147	**Claim denied. E&M procedure not allowed same DOS as Administration procedure**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered

9147	**Claim denied. E&M procedure not allowed same DOS as Administration procedure**	**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.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
9147	**Claim denied. E&M procedure not allowed same DOS as Administration procedure**	**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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
9148	**Recoup. E&M procedure and Administration procedure not allowed same DOS**	**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.	**187**	Date(s) of service.
9148	**Recoup. E&M procedure and Administration procedure not allowed same DOS**	**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.	**N20**	Service not payable with other service rendered on the same date	**187**	Date(s) of service.

9148	**Recoup. E&M procedure and Administration procedure not allowed same DOS**	**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.	**453**	Procedure Code Modifier(s) for Service(s) Rendered
9148	**Recoup. E&M procedure and Administration procedure not allowed same DOS**	**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.	**N20**	Service not payable with other service rendered on the same date	**453**	Procedure Code Modifier(s) for Service(s) Rendered
9149	**Procedure must be billed with the required E&M or Administration procedure 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).	**454**	Procedure code for services rendered
9149	**Procedure must be billed with the required E&M or Administration procedure 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.	**N19**	Procedure code incidental to primary procedure	**454**	Procedure code for services rendered

9150	**Administration procedure code must be billed with Botulinum Toxin A**	**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).	**454**	Procedure code for services rendered
9150	**Administration procedure code must be billed with Botulinum Toxin A**	**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.	**N19**	Procedure code incidental to primary procedure	**454**	Procedure code for services rendered
9151	**Claim denied. Product is not covered in the Pharmacy program**	**125**	Submission-billing error(s)	**N59**	Please refer to your provider manual for additional program and provider information.	**585**	Denied Charge or Non-covered Charge.
9152	**Claim denied, product is rebatable, but no pricing on file**	**125**	Submission-billing error(s)	**N59**	Please refer to your provider manual for additional program and provider information.	**585**	Denied Charge or Non-covered Charge.
9170	**One refraction allowed per two years for recipients age 21 and older**	**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.
9171	**One refraction allowed per year for recipients under age 21**	**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.

9174	**Thanks for reporting this vaccine to our database! This code is free thru VFC & therefore not reimbursable thru Medicaid in the future, report this vaccine w-new codes 90744-90747.**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	**M41**	We do not pay for this as the patient has no legal obligation to pay for this.	**15**	One or more originally submitted procedure code have been modified.
9174	**Thanks for reporting this vaccine to our database! This code is free thru VFC & therefore not reimbursable thru Medicaid in the future, report this vaccine w-new codes 90744-90747.**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	**M41**	We do not pay for this as the patient has no legal obligation to pay for this.	**19**	Entity acknowledges receipt of claim-encounter.
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.
9182	**Service Denied. Maximum units allowed per week have been exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**259**	Frequency of service.
9182	**Service Denied. Maximum units allowed per week have been exceeded.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same-similar procedure within set time frame.	**452**	Total visits in total number of hours-day and total number of hours-week.
9184	**Product requires insulin/Byetta script fill within the past 90 days**	**125**	Submission-billing error(s)	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**221**	Drug days supply and dosage.
9184	**Product requires insulin/Byetta script fill within the past 90 days**	**125**	Submission-billing error(s)	**N161**	This drug-service-supply is covered only when the associated service is covered.	**221**	Drug days supply and dosage.
9184	**Product requires insulin/Byetta script fill within the past 90 days**	**125**	Submission-billing error(s)	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**585**	Denied Charge or Non-covered Charge

9184	**Product requires insulin/Byetta script fill within the past 90 days**	**125**	Submission-billing error(s)	**N161**	This drug-service-supply is covered only when the associated service is covered.	**585**	Denied Charge or Non-covered Charge
9185	**ONLY ONE OVERRIDE FOR ORAL ANTICOAGULANTS**	**B5**	Coverage-program guidelines were not met or were exceeded.		**No Mapping Required**	**104**	Processed according to plan provisions. Plan refers to provisions that exist between the Health Plan and the Consumer or Patient.
9198	**All NDC units must be greater than zero. Please resubmit claim.**	**A1**	Claim-Service denied	**M53**	Missing-incomplete-invalid days or units of service.	**476**	Missing or invalid units of service
9199	**Target Case Management - Early Intervention (T1017 HI) is limited to $6000.00 in services per year. This dollar limitation has been exceeded**	**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.
9200	**DRG - inpatient stay requires accommodation revenue code. 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.
9201	**DRG - admission date and discharge date the same on inpatient claim. Resubmit as outpatient services.**	**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.
9202	**DRG - admission hour is invalid (not 00 through 23). Correct and resubmit claim.**	**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.

9202	**DRG - admission hour is invalid (not 00 through 23). Correct and resubmit claim.**	**125**	Submission-billing error(s)	**N46**	Missing-incomplete-invalid admission hour.	**230**	Hospital admission hour.
9202	**DRG - admission hour is invalid (not 00 through 23). Correct and resubmit claim.**	**125**	Submission-billing error(s)	**N46**	Missing-incomplete-invalid admission hour.	**256**	DRG code(s).
9203	**DRG - discharge hour is invalid (not 00 through 23). Correct and resubmit claim.**	**125**	Submission-billing error(s)	**N317**	Missing-incomplete-invalid discharge hour.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9203	**DRG - discharge hour is invalid (not 00 through 23). Correct and resubmit claim.**	**125**	Submission-billing error(s)	**N317**	Missing-incomplete-invalid discharge hour.	**233**	Hospital discharge hour
9203	**DRG - discharge hour is invalid (not 00 through 23). Correct and resubmit claim.**	**125**	Submission-billing error(s)	**N317**	Missing-incomplete-invalid discharge hour.	**256**	DRG code(s).
9204	**DRG-observation over 30 hrs on outpt claim. Resubmit charges on inpt claim (correct bill type, revenue code). If multiple encounters, bill each on separate outpt 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.
9205	**DRG - patient status is not valid with 3rd digit frequency of type of bill. Correct patient status or bill type and resubmit claim.**	**125**	Submission-billing error(s)	**MA30**	Missing-incomplete-invalid type of bill.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9205	**DRG - patient status is not valid with 3rd digit frequency of type of bill. Correct patient status or bill type and resubmit claim.**	**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.

9205	**DRG - patient status is not valid with 3rd digit frequency of type of bill. Correct patient status or bill type and resubmit claim.**	**125**	Submission-billing error(s)	**MA30**	Missing-incomplete-invalid type of bill.	**228**	Type of bill for UB claim.
9205	**DRG - patient status is not valid with 3rd digit frequency of type of bill. Correct patient status or bill type and resubmit claim.**	**125**	Submission-billing error(s)	**MA43**	Missing-incomplete-invalid patient status.	**228**	Type of bill for UB claim.
9205	**DRG - patient status is not valid with 3rd digit frequency of type of bill. Correct patient status or bill type and resubmit claim.**	**125**	Submission-billing error(s)	**MA30**	Missing-incomplete-invalid type of bill.	**256**	DRG code(s).
9205	**DRG - patient status is not valid with 3rd digit frequency of type of bill. Correct patient status or bill type and resubmit claim.**	**125**	Submission-billing error(s)	**MA43**	Missing-incomplete-invalid patient status.	**256**	DRG code(s).
9206	**DRG - interim claims must reflect span of dates over sixty days to be accepted for reimbursement by Medicaid. 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.
9207	**DRG - admitting diagnosis (FL 76) is required. 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.

9207	**DRG - admitting diagnosis (FL 76) is required. 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.	**488**	Diagnosis code(s) for the services rendered
9208	**DRG - principal diagnosis (FL 67) is required. 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.
9208	**DRG - principal diagnosis (FL 67) is required. 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.	**488**	Diagnosis code(s) for the services rendered
9209	**DRG - admitting diagnosis code is invalid or requires further subdivision. Correct and resubmit.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**MA65**	Missing-incomplete-invalid admitting diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9209	**DRG - admitting diagnosis code is invalid or requires further subdivision. Correct and resubmit.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**MA65**	Missing-incomplete-invalid admitting diagnosis.	**232**	Admitting diagnosis.
9209	**DRG - admitting diagnosis code is invalid or requires further subdivision. Correct and resubmit.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**MA65**	Missing-incomplete-invalid admitting diagnosis.	**256**	DRG code(s).

9210	**DRG - principal diagnosis code (FL 67) is invalid or requires further subdivision. Correct and resubmit cla.**	**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.
9210	**DRG - principal diagnosis code (FL 67) is invalid or requires further subdivision. Correct and resubmit cla.**	**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.	**488**	Diagnosis code(s) for the services rendered
9211	**DRG - other diagnosis code 2 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9211	**DRG - other diagnosis code 2 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
9211	**DRG - other diagnosis code 2 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9212	**DRG - other diagnosis code 3 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9212	**DRG - other diagnosis code 3 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.

9212	**DRG - other diagnosis code 3 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9213	**DRG - other diagnosis code 4 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9213	**DRG - other diagnosis code 4 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
9213	**DRG - other diagnosis code 4 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9214	**DRG - other diagnosis code 5 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9214	**DRG - other diagnosis code 5 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
9214	**DRG - other diagnosis code 5 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9215	**DRG - other diagnosis code 6 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

9215	**DRG - other diagnosis code 6 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
9215	**DRG - other diagnosis code 6 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9216	**DRG - other diagnosis code 7 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9216	**DRG - other diagnosis code 7 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
9216	**DRG - other diagnosis code 7 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9217	**DRG - other diagnosis code 8 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9217	**DRG - other diagnosis code 8 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
9217	**DRG - other diagnosis code 8 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).

9218	**DRG - other dx code equal to or greater than 9 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
9218	**DRG - other dx code equal to or greater than 9 is invalid or requires further subdivision. Correct and resubmit claim.**	**146**	Diagnosis was invalid for the date(s) of service reported.	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9219	**DRG Principal diagnosis invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines.**	**10**	The diagnosis is inconsistent with the patients gender. 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	**M64**	Missing-incomplete-invalid other diagnosis.	**86**	Diagnosis and patient gender mismatch.
9219	**DRG Principal diagnosis invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines.**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9220	**DRG Other diagnosis code 2 invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M64**	Missing-incomplete-invalid other diagnosis.	**86**	Diagnosis and patient gender mismatch.
9220	**DRG Other diagnosis code 2 invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines**	**10**	The diagnosis is inconsistent with the patients gender. 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.	**256**	DRG code(s).

9221	**DRG Other diagnosis code 3 invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M64**	Missing-incomplete-invalid other diagnosis.	**86**	Diagnosis and patient gender mismatch.
9221	**DRG Other diagnosis code 3 invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines**	**10**	The diagnosis is inconsistent with the patients gender. 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.	**256**	DRG code(s).
9222	**DRG Other diagnosis code 4 invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M64**	Missing-incomplete-invalid other diagnosis.	**86**	Diagnosis and patient gender mismatch.
9222	**DRG Other diagnosis code 4 invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines**	**10**	The diagnosis is inconsistent with the patients gender. 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.	**256**	DRG code(s).
9223	**DRG Other diagnosis code 5 invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M64**	Missing-incomplete-invalid other diagnosis.	**86**	Diagnosis and patient gender mismatch.
9223	**DRG Other diagnosis code 5 invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines**	**10**	The diagnosis is inconsistent with the patients gender. 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.	**256**	DRG code(s).
9224	**DRG Other diagnosis code 6 invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M64**	Missing-incomplete-invalid other diagnosis.	**86**	Diagnosis and patient gender mismatch.

9224	**DRG Other diagnosis code 6 invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines**	**10**	The diagnosis is inconsistent with the patients gender. 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.	**256**	DRG code(s).
9225	**DRG Other diagnosis code 7 invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M64**	Missing-incomplete-invalid other diagnosis.	**86**	Diagnosis and patient gender mismatch.
9225	**DRG Other diagnosis code 7 invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines**	**10**	The diagnosis is inconsistent with the patients gender. 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.	**256**	DRG code(s).
9226	**DRG Other diagnosis code 8 invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M64**	Missing-incomplete-invalid other diagnosis.	**86**	Diagnosis and patient gender mismatch.
9226	**DRG Other diagnosis code 8 invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines**	**10**	The diagnosis is inconsistent with the patients gender. 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.	**256**	DRG code(s).
9227	**DRG Other dx code equal to or greater than 9 invlaid for recipeint sex. If MID & dx are correct, submit claim to DMA claims analysis unit. See billing guidelines.**	**10**	The diagnosis is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	**M64**	Missing-incomplete-invalid other diagnosis.	**86**	Diagnosis and patient gender mismatch.

9227	**DRG Other dx code equal to or greater than 9 invlaid for recipeint sex. If MID & dx are correct, submit claim to DMA claims analysis unit. See billing guidelines.analysis unit, see billing guidelines**	**10**	The diagnosis is inconsistent with the patients gender. 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.	**256**	DRG code(s).
9228	**Principal diagnosis invalid for recipient age. If MID and diagnosis are correct resubmit claim as an adjustment with statement from physician attached**	**9**	The diagnosis is inconsistent with the patients age.	**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.
9228	**Principal diagnosis invalid for recipient age. If MID and diagnosis are correct resubmit claim as an adjustment with statement from physician attached**	**9**	The diagnosis is inconsistent with the patients age.	**M76**	Missing-incomplete-invalid diagnosis or condition.	**254**	Primary diagnosis code.
9228	**Principal diagnosis invalid for recipient age. If MID and diagnosis are correct resubmit claim as an adjustment with statement from physician attached**	**9**	The diagnosis is inconsistent with the patients age.	**M76**	Missing-incomplete-invalid diagnosis or condition.	**255**	Diagnosis code.
9229	**Other diagnosis code 2 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9229	**Other diagnosis code 2 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.

9229	**Other diagnosis code 2 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9230	**Other diagnosis code 3 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9230	**Other diagnosis code 3 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
9230	**Other diagnosis code 3 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9231	**Other diagnosis code 4 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9231	**Other diagnosis code 4 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
9231	**Other diagnosis code 4 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).

9232	**Other diagnosis code 5 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9232	**Other diagnosis code 5 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
9232	**Other diagnosis code 5 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9233	**Other diagnosis code 6 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9233	**Other diagnosis code 6 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
9233	**Other diagnosis code 6 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9234	**Other diagnosis code 7 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

9234	**Other diagnosis code 7 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
9234	**Other diagnosis code 7 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9235	**Other diagnosis code 8 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9235	**Other diagnosis code 8 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
9235	**Other diagnosis code 8 invalid for recipient age. If MID and diagnosis code are correct resubmit as an adjustment with statement from physician attached.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9236	**Other diagnosis code eqaul to or greater than 9 invalid for recipient age. If MID and diagnosis code are correct resubmit an adjustment w/ statement from physician.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

9236	**Other diagnosis code eqaul to or greater than 9 invalid for recipient age. If MID and diagnosis code are correct resubmit an adjustment w/ statement from physician.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**255**	Diagnosis code.
9236	**DRG-other procedure code equal to or greater than 6 is invalid or requires further subdivision. Correct and resubmit claim.**	**9**	The diagnosis is inconsistent with the patients age.	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9237	**DRG- Admitting diagnosis not allowed for type of admission,.**	**11**	The diagnosis is inconsistent with the procedure.	**MA65**	Missing-incomplete-invalid admitting diagnosis.	**231**	Hospital admission type.
9237	**DRG- Admitting diagnosis not allowed for type of admission,.**	**11**	The diagnosis is inconsistent with the procedure.	**MA65**	Missing-incomplete-invalid admitting diagnosis.	**232**	Admitting diagnosis.
9237	**DRG- Admitting diagnosis not allowed for type of admission,.**	**11**	The diagnosis is inconsistent with the procedure.	**MA65**	Missing-incomplete-invalid admitting diagnosis.	**256**	DRG code(s).
9238	**DRG - principal diagnosis code (FL 67) is the manifestation of an underlying disease or condition. Correct principal DX code to the underlying condition 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.
9238	**DRG - principal diagnosis code (FL 67) is the manifestation of an underlying disease or condition. Correct principal DX code to the underlying condition 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.	**488**	Diagnosis code(s) for the services rendered.

9239	**DRG - principal diagnosis (FL 67) cannot be 'E' code. Correct principal DX to condition, illness, or injury requiring admission 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.
9239	**DRG - principal diagnosis (FL 67) cannot be 'E' code. Correct principal DX to condition, illness, or injury requiring admission 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.	**488**	Diagnosis code(s) for the services rendered.
9240	**DRG - principal diagnosis code (FL 67) unacceptable for admission to acute care hospital. 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.
9240	**DRG - principal diagnosis code (FL 67) unacceptable for admission to acute care hospital. 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.	**488**	Diagnosis code(s) for the services rendered.
9241	**DRG - principal diagnosis (FL 67) unacceptable for admission without additional diagnosis. 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.

9241	**DRG - principal diagnosis (FL 67) unacceptable for admission without additional diagnosis. 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.	**488**	Diagnosis code(s) for the services rendered.
9242	**DRG - other diagnosis 2 is duplicate of principal diagnosis. Correct and resubmit claim.**	**125**	Submission-billing error(s)	**M64**	Missing-incomplete-invalid other diagnosis.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9242	**DRG - other diagnosis 2 is duplicate of principal diagnosis. Correct and resubmit claim.**	**125**	Submission-billing error(s)	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9242	**DRG - other diagnosis 2 is duplicate of principal diagnosis. Correct and resubmit claim.**	**125**	Submission-billing error(s)	**M64**	Missing-incomplete-invalid other diagnosis.	**488**	Diagnosis code(s) for the services rendered.
9243	**DRG - principal procedure code is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**MA66**	Missing-incomplete-invalid principal procedure code	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9243	**DRG - principal procedure code is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**MA66**	Missing-incomplete-invalid principal procedure code	**256**	DRG code(s).
9243	**DRG - principal procedure code is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**MA66**	Missing-incomplete-invalid principal procedure code	**465**	Principal Procedure Code for Service(s) Rendered.
9244	**DRG - other procedure code 2 is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**M67**	Missing-incomplete-invalid other procedure code(s).	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

9244	**DRG - other procedure code 2 is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**M67**	Missing-incomplete-invalid other procedure code(s).	**256**	DRG code(s).
9244	**DRG - other procedure code 2 is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**M67**	Missing-incomplete-invalid other procedure code(s).	**490**	Other procedure code for service(s) rendered.
9245	**DRG - other procedure code 3 is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**M67**	Missing-incomplete-invalid other procedure code(s).	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9245	**DRG - other procedure code 3 is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**M67**	Missing-incomplete-invalid other procedure code(s).	**256**	DRG code(s).
9245	**DRG - other procedure code 3 is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**M67**	Missing-incomplete-invalid other procedure code(s).	**490**	Other procedure code for service(s) rendered.
9246	**DRG - other procedure code 4 is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**M67**	Missing-incomplete-invalid other procedure code(s).	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9246	**DRG - other procedure code 4 is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**M67**	Missing-incomplete-invalid other procedure code(s).	**256**	DRG code(s).
9246	**DRG - other procedure code 4 is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**M67**	Missing-incomplete-invalid other procedure code(s).	**490**	Other procedure code for service(s) rendered.

9247	**DRG - other procedure code 5 is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**M67**	Missing-incomplete-invalid other procedure code(s).	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9247	**DRG - other procedure code 5 is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**M67**	Missing-incomplete-invalid other procedure code(s).	**256**	DRG code(s).
9247	**DRG - other procedure code 5 is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**M67**	Missing-incomplete-invalid other procedure code(s).	**490**	Other procedure code for service(s) rendered.
9248	**DRG - other procedure code 6 is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**M67**	Missing-incomplete-invalid other procedure code(s).	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9248	**DRG - other procedure code 6 is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**M67**	Missing-incomplete-invalid other procedure code(s).	**256**	DRG code(s).
9248	**DRG - other procedure code 6 is invalid or requires further subdivision. Correct and resubmit claim.**	**181**	Procedure code was invalid on the date of service	**M67**	Missing-incomplete-invalid other procedure code(s).	**490**	Other procedure code for service(s) rendered.
9249	**DRG Principal procedure invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. 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	**MA66**	Missing-incomplete-invalid principal procedure code or date.	**256**	DRG code(s).

9249	**DRG Principal procedure invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.	**256**	DRG code(s).
9249	**DRG Principal procedure invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. 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.	**465**	Principal Procedure Code for Service(s) Rendered.
9249	**DRG Principal procedure invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.	**465**	Principal Procedure Code for Service(s) Rendered.
9250	**DRG Other procedure code 2 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**M67**	Missing-incomplete-invalid other procedure code(s).	**256**	DRG code(s).
9250	**DRG Other procedure code 2 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.	**256**	DRG code(s).
9250	**DRG Other procedure code 2 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**M67**	Missing-incomplete-invalid other procedure code(s).	**474**	Procedure code and patient gender mismatch.

9250	**DRG Other procedure code 2 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.	**474**	Procedure code and patient gender mismatch.
9250	**DRG Other procedure code 2 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**M67**	Missing-incomplete-invalid other procedure code(s).	**490**	Other procedure code for service(s) rendered.
9250	**DRG Other procedure code 2 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.	**490**	Other procedure code for service(s) rendered.
9251	**DRG Other procedure code 3 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**M67**	Missing-incomplete-invalid other procedure code(s).	**256**	DRG code(s).
9251	**DRG Other procedure code 3 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.	**256**	DRG code(s).
9251	**DRG Other procedure code 3 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**M67**	Missing-incomplete-invalid other procedure code(s).	**474**	Procedure code and patient gender mismatch.

9251	**DRG Other procedure code 3 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.	**474**	Procedure code and patient gender mismatch.
9251	**DRG Other procedure code 3 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**M67**	Missing-incomplete-invalid other procedure code(s).	**490**	Other procedure code for service(s) rendered.
9251	**DRG Other procedure code 3 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.	**490**	Other procedure code for service(s) rendered.
9252	**DRG Other procedure code 4 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**M67**	Missing-incomplete-invalid other procedure code(s).	**256**	DRG code(s).
9252	**DRG Other procedure code 4 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.	**256**	DRG code(s).
9252	**DRG Other procedure code 4 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**M67**	Missing-incomplete-invalid other procedure code(s).	**474**	Procedure code and patient gender mismatch.

9252	**DRG Other procedure code 4 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.	**474**	Procedure code and patient gender mismatch.
9252	**DRG Other procedure code 4 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**M67**	Missing-incomplete-invalid other procedure code(s).	**490**	Other procedure code for service(s) rendered.
9252	**DRG Other procedure code 4 invalid for recipient sex. If MID and ICD-9 procedure are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.	**490**	Other procedure code for service(s) rendered.
9253	**DRG Other procedure code 5 invalid for recipient sex. If MID and ICD-9px are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**M67**	Missing-incomplete-invalid other procedure code(s).	**256**	DRG code(s).
9253	**DRG Other procedure code 5 invalid for recipient sex. If MID and ICD-9px are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.	**256**	DRG code(s).
9253	**DRG Other procedure code 5 invalid for recipient sex. If MID and ICD-9px are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**M67**	Missing-incomplete-invalid other procedure code(s).	**474**	Procedure code and patient gender mismatch.

9253	**DRG Other procedure code 5 invalid for recipient sex. If MID and ICD-9px are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.	**474**	Procedure code and patient gender mismatch.
9253	**DRG Other procedure code 5 invalid for recipient sex. If MID and ICD-9px are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**M67**	Missing-incomplete-invalid other procedure code(s).	**490**	Other procedure code for service(s) rendered.
9253	**DRG Other procedure code 5 invalid for recipient sex. If MID and ICD-9px are correct, submit claim to DMA Claims Analysis Unit, see billing guidelines**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.	**490**	Other procedure code for service(s) rendered.
9254	**DRG-other procedure equal to or greater than 6 invalid for recipient sex. If MID and ICD-9 px are correct, submit claim to DMA claims Analysis Unit, see billing guidelines.**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**M67**	Missing-incomplete-invalid other procedure code(s).	**256**	DRG code(s).
9254	**DRG-other procedure equal to or greater than 6 invalid for recipient sex. If MID and ICD-9 px are correct, submit claim to DMA claims Analysis Unit, see billing guidelines.**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.	**256**	DRG code(s).
9254	**DRG-other procedure equal to or greater than 6 invalid for recipient sex. If MID and ICD-9 px are correct, submit claim to DMA claims Analysis Unit, see billing guidelines.**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**M67**	Missing-incomplete-invalid other procedure code(s).	**474**	Procedure code and patient gender mismatch.

9254	**DRG-other procedure equal to or greater than 6 invalid for recipient sex. If MID and ICD-9 px are correct, submit claim to DMA claims Analysis Unit, see billing guidelines.**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.	**474**	Procedure code and patient gender mismatch.
9254	**DRG-other procedure equal to or greater than 6 invalid for recipient sex. If MID and ICD-9 px are correct, submit claim to DMA claims Analysis Unit, see billing guidelines.**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**M67**	Missing-incomplete-invalid other procedure code(s).	**490**	Other procedure code for service(s) rendered.
9254	**DRG-other procedure equal to or greater than 6 invalid for recipient sex. If MID and ICD-9 px are correct, submit claim to DMA claims Analysis Unit, see billing guidelines.**	**7**	The procedure-revenue code is inconsistent with the patients gender. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present	**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.	**490**	Other procedure code for service(s) rendered.
9255	**DRG Bilateral principal procedure. Please attach operative record and resubmit claim as an adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**256**	DRG code(s).
9255	**DRG Bilateral principal procedure. Please attach operative record and resubmit claim as an adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**465**	Principal Procedure Code for Service(s) Rendered.
9256	**DRG Other diagnosis 3 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**54**	Duplicate of a previously processed claim-line.
9256	**DRG Other diagnosis 3 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**54**	Duplicate of a previously processed claim-line.
9256	**DRG Other diagnosis 3 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).

9256	**DRG Other diagnosis 3 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**256**	DRG code(s).
9256	**DRG Other diagnosis 3 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**488**	Diagnosis code(s) for the services rendered.
9256	**DRG Other diagnosis 3 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.
9257	**DRG Other diagnosis 4 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**54**	Duplicate of a previously processed claim-line.
9257	**DRG Other diagnosis 4 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**54**	Duplicate of a previously processed claim-line.
9257	**DRG Other diagnosis 4 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9257	**DRG Other diagnosis 4 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**256**	DRG code(s).
9257	**DRG Other diagnosis 4 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**488**	Diagnosis code(s) for the services rendered.
9257	**DRG Other diagnosis 4 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.
9258	**DRG Other diagnosis 5 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**54**	Duplicate of a previously processed claim-line.

9258	**DRG Other diagnosis 5 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**54**	Duplicate of a previously processed claim-line.
9258	**DRG Other diagnosis 5 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9258	**DRG Other diagnosis 5 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**256**	DRG code(s).
9258	**DRG Other diagnosis 5 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**488**	Diagnosis code(s) for the services rendered.
9258	**DRG Other diagnosis 5 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.
9259	**DRG Other diagnosis 6 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**54**	Duplicate of a previously processed claim-line.
9259	**DRG Other diagnosis 6 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**54**	Duplicate of a previously processed claim-line.
9259	**DRG Other diagnosis 6 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9259	**DRG Other diagnosis 6 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**256**	DRG code(s).
9259	**DRG Other diagnosis 6 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**488**	Diagnosis code(s) for the services rendered.

9259	**DRG Other diagnosis 6 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.
9260	**DRG Other diagnosis 7 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**54**	Duplicate of a previously processed claim-line.
9260	**DRG Other diagnosis 7 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**54**	Duplicate of a previously processed claim-line.
9260	**DRG Other diagnosis 7 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9260	**DRG Other diagnosis 7 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**256**	DRG code(s).
9260	**DRG Other diagnosis 7 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**488**	Diagnosis code(s) for the services rendered.
9260	**DRG Other diagnosis 7 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.
9261	**DRG Other diagnosis 8 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**54**	Duplicate of a previously processed claim-line.
9261	**DRG Other diagnosis 8 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**54**	Duplicate of a previously processed claim-line.
9261	**DRG Other diagnosis 8 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).

9261	**DRG Other diagnosis 8 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**256**	DRG code(s).
9261	**DRG Other diagnosis 8 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**488**	Diagnosis code(s) for the services rendered.
9261	**DRG Other diagnosis 8 is duplicate of principal diagnosis. Correct and resubmit.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.
9262	**DRG Other diagnosis equal to or greater than 9 is duplicate of principal diagnosis. Correct and resubmit claim.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**54**	Duplicate of a previously processed claim-line.
9262	**DRG Other diagnosis equal to or greater than 9 is duplicate of principal diagnosis. Correct and resubmit claim.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**54**	Duplicate of a previously processed claim-line.
9262	**DRG Other diagnosis equal to or greater than 9 is duplicate of principal diagnosis. Correct and resubmit claim.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**256**	DRG code(s).
9262	**DRG Other diagnosis equal to or greater than 9 is duplicate of principal diagnosis. Correct and resubmit claim.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**256**	DRG code(s).
9262	**DRG Other diagnosis equal to or greater than 9 is duplicate of principal diagnosis. Correct and resubmit claim.**	**18**	Exact duplicate claim-service	**M64**	Missing-incomplete-invalid other diagnosis.	**488**	Diagnosis code(s) for the services rendered.
9262	**DRG Other diagnosis equal to or greater than 9 is duplicate of principal diagnosis. Correct and resubmit claim.**	**18**	Exact duplicate claim-service	**M76**	Missing-incomplete-invalid diagnosis or condition.	**488**	Diagnosis code(s) for the services rendered.

9263	**DRG - bilateral procedure 2: please attach operative record and submit claim as an adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**256**	DRG code(s).
9263	**DRG - bilateral procedure 2: please attach operative record and submit claim as an 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.	**256**	DRG code(s).
9263	**DRG - bilateral procedure 2: please attach operative record and submit claim as an adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**298**	Operative report.
9263	**DRG - bilateral procedure 2: please attach operative record and submit claim as an 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.	**298**	Operative report.
9263	**DRG - bilateral procedure 2: please attach operative record and submit claim as an adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**454**	Procedure code for services rendered.
9263	**DRG - bilateral procedure 2: please attach operative record and submit claim as an 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.	**454**	Procedure code for services rendered.
9264	**DRG - bilateral procedure 3: please attach operative record and submit claim as an adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**256**	DRG code(s).

9264	**DRG - bilateral procedure 3: please attach operative record and submit claim as an 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.	**256**	DRG code(s).
9264	**DRG - bilateral procedure 3: please attach operative record and submit claim as an adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**298**	Operative report.
9264	**DRG - bilateral procedure 3: please attach operative record and submit claim as an 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.	**298**	Operative report.
9264	**DRG - bilateral procedure 3: please attach operative record and submit claim as an adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**454**	Procedure code for services rendered.
9264	**DRG - bilateral procedure 3: please attach operative record and submit claim as an 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.	**454**	Procedure code for services rendered.
9265	**DRG - bilateral procedure 4: please attach operative record and submit claim as an adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**256**	DRG code(s).
9265	**DRG - bilateral procedure 4: please attach operative record and submit claim as an 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.	**256**	DRG code(s).

9265	**DRG - bilateral procedure 4: please attach operative record and submit claim as an adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**298**	Operative report.
9265	**DRG - bilateral procedure 4: please attach operative record and submit claim as an 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.	**298**	Operative report.
9265	**DRG - bilateral procedure 4: please attach operative record and submit claim as an adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**454**	Procedure code for services rendered.
9265	**DRG - bilateral procedure 4: please attach operative record and submit claim as an 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.	**454**	Procedure code for services rendered.
9266	**DRG - bilateral procedure 5: please attach operative record and submit claim as an adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**256**	DRG code(s).
9266	**DRG - bilateral procedure 5: please attach operative record and submit claim as an 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.	**256**	DRG code(s).
9266	**DRG - bilateral procedure 5: please attach operative record and submit claim as an adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**298**	Operative report.

9266	**DRG - bilateral procedure 5: please attach operative record and submit claim as an 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.	**298**	Operative report.
9266	**DRG - bilateral procedure 5: please attach operative record and submit claim as an adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**454**	Procedure code for services rendered.
9266	**DRG - bilateral procedure 5: please attach operative record and submit claim as an 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.	**454**	Procedure code for services rendered.
9267	**DRG - bilateral procedure equal to or greater than 6; Please attach operative record and submit claim as and adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**256**	DRG code(s).
9267	**DRG - bilateral procedure equal to or greater than 6; Please attach operative record and submit claim as and 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.	**256**	DRG code(s).
9267	**DRG - bilateral procedure equal to or greater than 6; Please attach operative record and submit claim as and adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**298**	Operative report.
9267	**DRG - bilateral procedure equal to or greater than 6; Please attach operative record and submit claim as and 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.	**298**	Operative report.

9267	**DRG - bilateral procedure equal to or greater than 6; Please attach operative record and submit claim as and adjustment.**	**16**	Claim-service lacks information which is needed for adjudication	**M29**	Missing operative report.	**454**	Procedure code for services rendered.
9267	**DRG - bilateral procedure equal to or greater than 6; Please attach operative record and submit claim as and 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.	**454**	Procedure code for services rendered.
9268	**DRG - ungroupable claim data. DRG assigned by medical policy**	**A8**	Ungroupable DRG	**N65**	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service-provider.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9268	**DRG - ungroupable claim data. DRG assigned by medical policy**	**A8**	Ungroupable DRG	**N65**	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service-provider.	**256**	DRG code(s).
9269	**DRG - admission hour and discharge hour are invalid (not 00 through 23). Correct and resubmit claim**	**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.
9269	**DRG - admission hour and discharge hour are invalid (not 00 through 23). Correct and resubmit claim**	**125**	Submission-billing error(s)	**N50**	Missing-incomplete-invalid discharge information.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9269	**DRG - admission hour and discharge hour are invalid (not 00 through 23). Correct and resubmit claim**	**125**	Submission-billing error(s)	**N46**	Missing-incomplete-invalid admission hour.	**230**	Hospital admission hour.
9269	**DRG - admission hour and discharge hour are invalid (not 00 through 23). Correct and resubmit claim**	**125**	Submission-billing error(s)	**N50**	Missing-incomplete-invalid discharge information.	**230**	Hospital admission hour.

9269	**DRG - admission hour and discharge hour are invalid (not 00 through 23). Correct and resubmit claim**	**125**	Submission-billing error(s)	**N46**	Missing-incomplete-invalid admission hour.	**233**	Hospital discharge hour.
9269	**DRG - admission hour and discharge hour are invalid (not 00 through 23). Correct and resubmit claim**	**125**	Submission-billing error(s)	**N50**	Missing-incomplete-invalid discharge information.	**233**	Hospital discharge hour.
9270	**Additional accommodation details denied. Payment made on first accommodation detail only.**	**A1**	Claim-Service denied	**M50**	Missing-incomplete-invalid revenue code(s).	**65**	Claim-line has been paid.
9270	**Additional accommodation details denied. Payment made on first accommodation detail only.**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**65**	Claim-line has been paid.
9270	**Additional accommodation details denied. Payment made on first accommodation detail only.**	**A1**	Claim-Service denied	**M50**	Missing-incomplete-invalid revenue code(s).	**256**	DRG code(s).
9270	**Additional accommodation details denied. Payment made on first accommodation detail only.**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**256**	DRG code(s).
9270	**Additional accommodation details denied. Payment made on first accommodation detail only.**	**A1**	Claim-Service denied	**M50**	Missing-incomplete-invalid revenue code(s).	**455**	Revenue code for services rendered
9270	**Additional accommodation details denied. Payment made on first accommodation detail only.**	**A1**	Claim-Service denied	**N381**	Consult our contractual agreement for restrictions-billing-payment information related to these charges	**455**	Revenue code for services rendered
9271	**Payment included in DRG reimbursement on first accommodation detail**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	**M50**	Missing-incomplete-invalid revenue code(s).	**65**	Claim-line has been paid.

9271	**Payment included in DRG reimbursement on first accommodation detail**	**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.
9271	**Payment included in DRG reimbursement on first accommodation detail**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	**M50**	Missing-incomplete-invalid revenue code(s).	**256**	DRG code(s).
9271	**Payment included in DRG reimbursement on first accommodation detail**	**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	**256**	DRG code(s).
9271	**Payment included in DRG reimbursement on first accommodation detail**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	**M50**	Missing-incomplete-invalid revenue code(s).	**455**	Revenue code for services rendered
9271	**Payment included in DRG reimbursement on first accommodation detail**	**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	**455**	Revenue code for services rendered
9272	**DRG RCC code not on file for provider number.**	**52**	The referring-prescribing-rendering provider is not eligible to refer-prescribe-order-perform the service billed.	**N65**	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service-provider.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9272	**DRG RCC code not on file for provider number.**	**52**	The referring-prescribing-rendering provider is not eligible to refer-prescribe-order-perform the service billed.	**N65**	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service-provider.	**256**	DRG code(s).
9273	**Rate error. No DGR RCC code segment on file for provider number; or no segment for claim dates of service.**	**147**	Provider contracted-negotiated rate expired or not on file.	**N65**	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service-provider.	**256**	DRG code(s).

9274	**DRG - claim is ungroupable due to nonspecific code used as principal diagnosis (FL-67).**	**A8**	Ungroupable DRG	**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.
9274	**DRG - claim is ungroupable due to nonspecific code used as principal diagnosis (FL-67).**	**A8**	Ungroupable DRG	**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.	**488**	Diagnosis code(s) for the services rendered.
9275	**DRG - claim is ungroupable. Principal diagnosis (FL-67) is invalid as discharge diagnosis. Review claim to assure validity of data; modify and resubmit.**	**A8**	Ungroupable DRG	**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.
9275	**DRG - claim is ungroupable. Principal diagnosis (FL-67) is invalid as discharge diagnosis. Review claim to assure validity of data; modify and resubmit.**	**A8**	Ungroupable DRG	**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.	**488**	Diagnosis code(s) for the services rendered.
9278	**Drug limited to 210 units per calendar month. Units cutback to allowed amount**	**119**	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.
9278	**Drug limited to 210 units per calendar month. Units cutback to allowed amount**	**119**	Benefit maximum for this time period or occurrence has been reached	**N381**	N381 - Consult our contractual agreement for restrictions-billing-payment information related to these charges	**258**	Days-units for procedure-revenue code.

9278	**Drug limited to 210 units per calendar month. Units cutback to allowed amount**	**119**	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.
9278	**Drug limited to 210 units per calendar month. Units cutback to allowed amount**	**119**	Benefit maximum for this time period or occurrence has been reached	**N381**	N381 - Consult our contractual agreement for restrictions-billing-payment information related to these charges	**259**	Frequency of service.
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.
9293	**DRG - most current services 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).
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).
9300	**This revenue code must be billed with a valid 5 digit HCPCS code. Correct denied detail and refile as a new day claim.**	**16**	Claim-service lacks information which is needed for adjudication	**M20**	Missing-incomplete-invalid HCPCS.	**455**	Revenue code for services rendered.
9300	**This revenue code must be billed with a valid 5 digit HCPCS code. Correct denied detail and refile as a new day claim.**	**16**	Claim-service lacks information which is needed for adjudication	**N142**	The original claim was denied. Resubmit a new claim, not a replacement claim.	**455**	Revenue code for services rendered.
9300	**This revenue code must be billed with a valid 5 digit HCPCS code. Correct denied detail and refile as a new day claim.**	**16**	Claim-service lacks information which is needed for adjudication	**M20**	Missing-incomplete-invalid HCPCS.	**507**	HCPCS
9300	**This revenue code must be billed with a valid 5 digit HCPCS code. Correct denied detail and refile as a new day claim.**	**16**	Claim-service lacks information which is needed for adjudication	**N142**	The original claim was denied. Resubmit a new claim, not a replacement claim.	**507**	HCPCS
9301	**Exceeds maximum units allowed per 84 days same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service
9302	**No rate on file for indicated patient facility**	**52**	The referring-prescribing-rendering provider is not eligible to refer-prescribe-order-perform the service billed.	**N95**	This provider type -provider specialty may not bill this service.	**25**	Entity not approved.
9303	**State Fiscal Year (SFY) dollar limitation for this item per recipient is exceeded by the same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**259**	Frequency of service

9304	**State Fiscal Year (SFY) dollar limitation for this item per recipient without prior approval exceeded by the same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached	**M86**	Service denied because payment already made for same-similar procedure within set time frame	**259**	Frequency of service
9401	**Units cutback. Exceeds maximum units allowed per 84 days same or different provider**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**259**	Frequency of service
9491	**Does not meet Family Planning Waiver requirements**	**A1**	Claim-Service denied		**No Mapping Required**	**454**	Procedure code for services rendered.
9491	**Does not meet Family Planning Waiver requirements**	**A1**	Claim-Service denied		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge
9496	**NDC is Non-Rebatable**	**211**	National Drug Codes (NDC) not eligible for rebate, are not covered.		**No Mapping Required**	**218**	NDC number.
9497	**NDC is Non-Rebatable**	**211**	National Drug Codes (NDC) not eligible for rebate, are not covered.		**No Mapping Required**	**218**	NDC number.
9498	**Second NDC is Non-Rebatable**	**211**	National Drug Codes (NDC) not eligible for rebate, are not covered.		**No Mapping Required**	**218**	NDC number.
9499	**Third NDC is Non-Rebatable**	**211**	National Drug Codes (NDC) not eligible for rebate, are not covered.		**No Mapping Required**	**218**	NDC number.
9500	**Fourth NDC is Non-Rebatable**	**211**	National Drug Codes (NDC) not eligible for rebate, are not covered.		**No Mapping Required**	**218**	NDC number.
9501	**Fifth NDC is Non-Rebatable**	**211**	National Drug Codes (NDC) not eligible for rebate, are not covered.		**No Mapping Required**	**218**	NDC number.
9502	**Sixth NDC is Non-Rebatable**	**211**	National Drug Codes (NDC) not eligible for rebate, are not covered.		**No Mapping Required**	**218**	NDC number.
9503	**Seventh NDC is Non-Rebatable**	**211**	National Drug Codes (NDC) not eligible for rebate, are not covered.		**No Mapping Required**	**218**	NDC number.
9504	**Eigth NDC is Non-Rebatable**	**211**	National Drug Codes (NDC) not eligible for rebate, are not covered.		**No Mapping Required**	**218**	NDC number.

9505	**Ninth NDC is Non-Rebatable**	**211**	National Drug Codes (NDC) not eligible for rebate, are not covered.		**No Mapping Required**	**218**	NDC number.
9506	**Tenth NDC is Non-Rebatable**	**211**	National Drug Codes (NDC) not eligible for rebate, are not covered.		**No Mapping Required**	**218**	NDC number.
9509	**Service denied. Based on the NDC information provided a more specific HCPCS drug code must be billed instead of a the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**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.
9509	**Service denied. Based on the NDC information provided a more specific HCPCS drug code must be billed instead of a the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9509	**Service denied. Based on the NDC information provided a more specific HCPCS drug code must be billed instead of a the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**454**	Procedure code for services rendered.
9509	**Service denied. Based on the NDC information provided a more specific HCPCS drug code must be billed instead of a the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**454**	Procedure code for services rendered.
9510	**Service Denied. Based on the first NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and Resubmit.**	**A1**	Claim-Service denied	**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.

9510	**Service Denied. Based on the first NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and Resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9510	**Service Denied. Based on the first NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and Resubmit.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**454**	Procedure code for services rendered.
9510	**Service Denied. Based on the first NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and Resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**454**	Procedure code for services rendered.
9511	**Service denied. Based on the second NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**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.
9511	**Service denied. Based on the second NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

9511	**Service denied. Based on the second NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**454**	Procedure code for services rendered.
9511	**Service denied. Based on the second NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**454**	Procedure code for services rendered.
9512	**Service Denied. Based on the third NDC information provided a more specific drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**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.
9512	**Service Denied. Based on the third NDC information provided a more specific drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9512	**Service Denied. Based on the third NDC information provided a more specific drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**454**	Procedure code for services rendered.

9512	**Service Denied. Based on the third NDC information provided a more specific drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**454**	Procedure code for services rendered.
9513	**Service Denied. Based on the fourth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**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.
9513	**Service Denied. Based on the fourth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9513	**Service Denied. Based on the fourth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**454**	Procedure code for services rendered.
9513	**Service Denied. Based on the fourth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**454**	Procedure code for services rendered.
9514	**Service Denied. Based on the fifth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**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.

9514	**Service Denied. Based on the fifth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9514	**Service Denied. Based on the fifth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**454**	Procedure code for services rendered.
9514	**Service Denied. Based on the fifth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**454**	Procedure code for services rendered.
9515	**Service Denied. Based on the sixth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**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.
9515	**Service Denied. Based on the sixth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9515	**Service Denied. Based on the sixth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**454**	Procedure code for services rendered.

9515	**Service Denied. Based on the sixth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**454**	Procedure code for services rendered.
9516	**Service Denied. Based on the seventh NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**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.
9516	**Service Denied. Based on the seventh NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9516	**Service Denied. Based on the seventh NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**454**	Procedure code for services rendered.
9516	**Service Denied. Based on the seventh NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**454**	Procedure code for services rendered.

9517	**Service Denied. Based on the eighth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**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.
9517	**Service Denied. Based on the eighth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9517	**Service Denied. Based on the eighth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**454**	Procedure code for services rendered.
9517	**Service Denied. Based on the eighth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert- T**he NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**454**	Procedure code for services rendered.
9518	**Service Denied. Based on the ninth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**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.
9518	**Service Denied. Based on the ninth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

9518	**Service Denied. Based on the ninth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**454**	Procedure code for services rendered.
9518	**Service Denied. Based on the ninth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**454**	Procedure code for services rendered.
9519	**Service Denied. Based on the tenth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**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.
9519	**Service Denied. Based on the tenth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9519	**Service Denied. Based on the tenth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**454**	Procedure code for services rendered.
9519	**Service Denied. Based on the tenth NDC information provided a more specific HCPCS drug code must be billed instead of the miscellaneous code used. Correct and resubmit.**	**A1**	Claim-Service denied	**M70**	**Alert-** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	**454**	Procedure code for services rendered.

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
9603	**Paid in full by Medicare. No additional payment due. .**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**N192**	Patient is a Medicaid-Qualified Medicare Beneficiary.	**591**	Medicare Paid at 100% 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.
9612	**Adult Care Home services are not allowed when client is inpatient (ACUTE or LTC Facility). Correct and resubmit for service dates client was not hospitalized.**	**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.
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**	**A1**	Claim-Service denied	**N34**	Incorrect claim form-format for	**481**	Claim-submission format is
	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	**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.
9631	**Occurrence code entered in block 24 J of claim is not valid. Please correct 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.	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9631	**Occurrence code entered in block 24 J of claim is not valid. Please correct 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.	**720**	NUBC Occurrence Code Date(s)
9633	**The sum of other insurance payments indicated in block 24 K does not equal total third party payment entered in block 29. Please correct and resubmit as a new claim.**	**148**	Information from another provider was not provided or was insufficient-incomplete	**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.
9641	**This procedure is only payable to Pathology providers according to Medicaid guidelines.**	**52**	The referring-prescribing-rendering provider is not eligible to refer-prescribe-order-perform the service billed.	**N95**	This provider type - provider specialty may not bill this service.	**91**	Entity not eligible-not approved for dates of service.

9642	**Pathologist must bill this procedure with a type of service 04. Please correct and resubmit your 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.
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.
9684	**Records do not support the procedure billed, please review-correct-resubmit new day claim.**	**16**	Claim-service lacks information which is needed for adjudication	**N29**	Missing-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.
9701	**DETAIL HAS BEEN COMBINED PER THE LINK PRESCRIPTION NUMBER FOR PROCESSING AS A COMPOUND DRUG**	**97**	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated.	**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.
9701	**DETAIL HAS BEEN COMBINED PER THE LINK PRESCRIPTION NUMBER FOR PROCESSING AS A COMPOUND DRUG**	**97**	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated.	**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.	**216**	Drug information.
9702	**DOS AND/OR HCPCS/REVENUE CODES BILLED DO NOT MATCH FOR COMPOUND DRUG AS INDICATED BY THE LINK PRESCRIPTION NUMBER**	**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.

9702	**DOS AND/OR HCPCS/REVENUE CODES BILLED DO NOT MATCH FOR COMPOUND DRUG AS INDICATED BY THE LINK PRESCRIPTION NUMBER**	**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.	**216**	Drug information.
9703	**OT re-evaluation not allowed same day as OT evaluation.**	**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.
9704	**OT evaluation not allowed same day as OT re-evaluation**	**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.
9705	**EXCEEDS MAXIMUM ALLOWED OF 10 NDCS PER REVENUE CODE/HCPCS FOR COMPOUND DRUGS. REVIEW CLAIM AND RSUBMIT**	**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.

9705	**EXCEEDS MAXIMUM ALLOWED OF 10 NDCS PER REVENUE CODE/HCPCS FOR COMPOUND DRUGS. REVIEW CLAIM AND RSUBMIT**	**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.	**216**	Drug information.
9730	**Must bill with preferred vendor Prodigy prior to 11/15/2011**	**A1**	Claim-Service denied	**M16**	Alert: Please see our web site mailings or bulletins for more details concerning this policy-procedure-decision.	**21**	Missing or invalid information.
9730	**Must bill with preferred vendor Prodigy prior to 11/15/2011**	**A1**	Claim-Service denied	**M16**	Alert: Please see our web site mailings or bulletins for more details concerning this policy-procedure-decision.	**25**	Entity not approved
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.

9800	**F-U care is included in Radiation Management**	**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.
9801	**Routine physicals are not covered by Medicaid. Rebill Medicaid under code W8001, Adult Health Screening.**	**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.	**457**	Non-Covered Day(s)
9802	**Medicaid does not make payment for services Medicare denies as included in fee for surgery.**	**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.	**457**	Non-Covered Day(s)
9803	**Medicare claim denied as duplicate, resubmit with Medicare EOMB that shows payment for dates of service listed.**	**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.
9804	**Itemized statement does not include all information for services on Medicare claim. Correct, and resubmit.**	**A1**	Claim-Service denied	**N48**	Claim information does not agree with information received from other insurance carrier.	**275**	Claim.
9804	**Itemized statement does not include all information for services on Medicare claim. Correct, and resubmit.**	**A1**	Claim-Service denied	**N48**	Claim information does not agree with information received from other insurance carrier.	**279**	Itemized claim.
9805	**MEDICARE HAS ADJUSTED. FILE A MEDICAID ADJUSTMENT REQUEST WITH MEDICARE EOMB'S TO COMPLETE PAYMENT OF CLAIM**	**A1**	Claim-Service denied	**MA67**	Correction to a prior claim.	**286**	Other payer's Explanation of Benefits (EOB).

9805	**MEDICARE HAS ADJUSTED. FILE A MEDICAID ADJUSTMENT REQUEST WITH MEDICARE EOMB'S TO COMPLETE PAYMENT OF CLAIM**	**A1**	Claim-Service denied	**MA92**	Missing-incomplete-invalid plan information for other insurance.	**286**	Other payer's Explanation of Benefits (EOB).
9806	**This service is covered by Medicare for diagnosis on claim Request adj from Medicare for reconsideration.**	**22**	Payment adjusted because 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.
9807	**MEDICARE CLAIM HAS ITEMS LISTED THAT ARE NOT ON THE MEDICARE EOMB-VOUCHER. SUBMIT EOMB FOR EACH SERVICE BILLED OR DELETED CHARGE ON CLAIM AND RESUBMIT**	**148**	Information from another provider was not provided or was insufficient-incomplete	**N48**	Claim information does not agree with information received from other insurance carrier.	**279**	Itemized claim.
9807	**MEDICARE CLAIM HAS ITEMS LISTED THAT ARE NOT ON THE MEDICARE EOMB-VOUCHER. SUBMIT EOMB FOR EACH SERVICE BILLED OR DELETED CHARGE ON CLAIM AND RESUBMIT**	**148**	Information from another provider was not provided or was insufficient-incomplete	**N48**	Claim information does not agree with information received from other insurance carrier.	**286**	Other payer's Explanation of Benefits (EOB).
9808	**Claim denied by Medicare. Medicaid has already made payment for claim on a previous RA.**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**N195**	Patient is a Medicaid-Qualified Medicare Beneficiary.	**107**	Processed according to contract-plan provisions
9808	**Claim denied by Medicare. Medicaid has already made payment for claim on a previous RA.**	**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
9809	**NAME ON MEDICARE CLAIM DOES NOT MATCH NAME ON EOMB/VOUCHER**	**A1**	Claim-Service denied	**N48**	Claim information does not agree with information received from other insurance carrier.	**286**	Other payer's Explanation of Benefits (EOB).

9810	**Services recouped. Radiation management paid includes follow-up 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.
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).
9820	**Invalid coordination of benefits other payer ID qualifier. Valid qualifiers are: 01 through 04, 09, 99 or blank**	**A1**	Claim-Service denied	**N245**	Incomplete-invalid plan information for other insurance	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9821	**Invalid coordination of benefits reject count. Must be 01 through 05**	**A1**	Claim-Service denied	**N245**	Incomplete-invalid plan information for other insurance	**21**	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9825	**Exceeds legislative limits for provider visits for fiscal year.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
9825	**Exceeds legislative limits for provider visits for fiscal year.**	**119**	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**263**	Length of time for services rendered.
9827	**Exceeded legislative limit. Denied per medical consultant review.**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**259**	Frequency of service.
9827	**Exceeded legislative limit. Denied per medical consultant review.**	**A1**	Claim-Service denied	**N362**	The number of Days or Units of Service exceeds our acceptable maximum.	**263**	Length of time for services rendered.

9862	**Drug limted to 1800 units per calendar month. Units cutback to allowed amount**	**119**	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.
9862	**Drug limted to 1800 units per calendar month. Units cutback to allowed amount**	**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.
9862	**Drug limted to 1800 units per calendar month. Units cutback to allowed amount**	**119**	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
9862	**Drug limted to 1800 units per calendar month. Units cutback to allowed amount**	**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
9865	**One influenza procedure allowed per 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	**259**	Frequency of service
9872	**Two units of influenza procedures allowed within 240 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	**258**	Days-units for procedure-revenue code.
9872	**Two units of influenza procedures allowed within 240 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
9874	**Claim denied. A meningococcal vaccine has already been paid to the same or different provider for this date of service**	**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.

	Service denied as a result of pre-						

9906	**Patient is enrolled in a HMO plan. Delivery charges have been made to the HMO. Physicians may bill fee for service for care rendered on out-of-plan dates of service.**	**24**	Charges are covered under a capitation agreement-managed care plan		**No Mapping Required**	**88**	Entity not eligible for benefits for submitted dates of service. Note-This code requires use of an Entity Code.
9906	**Patient is enrolled in a HMO plan. Delivery charges have been made to the HMO. Physicians may bill fee for service for care rendered on out-of-plan dates of service.**	**24**	Charges are covered under a capitation agreement-managed care plan		**No Mapping Required**	**96**	No agreement with entity.
9919	**Recipient is not enrolled in billing provider's managed careplan for this date of service. Verify date of service of trigger claim and resubmit if appropriate.**	**30**	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	**N30**	Patient ineligible for this service.	**91**	Entity not eligible-not approved for dates of service.
9919	**Recipient is not enrolled in billing provider's managed careplan for this date of service. Verify date of service of trigger claim and resubmit if appropriate.**	**30**	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	**N30**	Patient ineligible for this service.	**515**	Managed Care review
9920	**No payment will be made on managed care trigger claim. Data has been tracked and a kick payment will be generated on the first remittance statement of the month.**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).		**No Mapping Required**	**19**	Entity acknowledges receipt of claim-encounter.
9920	**No payment will be made on managed care trigger claim. Data has been tracked and a kick payment will be generated on the first remittance statement of the month.**	**45**	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).		**No Mapping Required**	**515**	Managed Care review

9921	**Managed Care trigger claim must be filed with procedure code MC026. No kick payment claim will be generated. Correct code and refile trigger 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.
9921	**Managed Care trigger claim must be filed with procedure code MC026. No kick payment claim will be generated. Correct code and refile trigger 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.	**515**	Managed Care review
9922	**Trigger claims can be billed with only one detail per 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.
9923	**Patient is not covered under a managed care plan for this date of service. No kick payment will be generated.**	**30**	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	**N30**	Patient ineligible for this service.	**91**	Entity not eligible-not approved for dates of service.
9924	**From and through date of service must be the same for trigger claims.**	**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.
9925	**Primary diagnosis code must be a valid diagnosis for kick payments.**	**11**	The diagnosis is inconsistent with the procedure.	**M76**	Missing-incomplete-invalid diagnosis or condition.	**254**	Primary diagnosis code.

9930	**NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9930	**NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**454**	Procedure code for services rendered.
9931	**FIRST NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9931	**FIRST NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**454**	Procedure code for services rendered.
9932	**SECOND NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9932	**SECOND NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**454**	Procedure code for services rendered.
9933	**THIRD NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9933	**THIRD NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**454**	Procedure code for services rendered.
9934	**FOURTH NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9934	**FOURTH NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**454**	Procedure code for services rendered.

9935	**FIFTH NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9935	**FIFTH NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**454**	Procedure code for services rendered.
9936	**SIXTH NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9936	**SIXTH NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**454**	Procedure code for services rendered.
9937	**SEVENTH NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9937	**SEVENTH NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**454**	Procedure code for services rendered.
9938	**EIGHT NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9938	**EIGHT NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**454**	Procedure code for services rendered.
9939	**NINTH NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9939	**NINTH NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**454**	Procedure code for services rendered.

9940	**TENTH NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9940	**TENTH NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**454**	Procedure code for services rendered.
9941	**NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9941	**NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**585**	Denied Charge or Non-covered Charge
9942	**FIRST NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9942	**FIRST NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**585**	Denied Charge or Non-covered Charge
9943	**SECOND NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9943	**SECOND NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**585**	Denied Charge or Non-covered Charge
9944	**THIRD NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.

9944	**THIRD NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**585**	Denied Charge or Non-covered Charge
9945	**FOURTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9945	**FOURTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**585**	Denied Charge or Non-covered Charge
9946	**FIFTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9946	**FIFTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**585**	Denied Charge or Non-covered Charge
9947	**SIXTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9947	**SIXTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**585**	Denied Charge or Non-covered Charge
9948	**SEVENTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.

9948	**SEVENTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**585**	Denied Charge or Non-covered Charge
9949	**EIGHTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9949		**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**585**	Denied Charge or Non-covered Charge
9950	**NINTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9950	**NINTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**585**	Denied Charge or Non-covered Charge
9951	**TENTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9951	**TENTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**585**	Denied Charge or Non-covered Charge
9952	**NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**218**	NDC number.
9952	**NDC IS DESI (LESS THAN EFFECTIVE)**	**A1**	Claim-Service denied	**M16**	**Alert**- Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	**454**	Procedure code for services rendered.

9953	**PAYMENT OF PROCEDURE IS DENIED BASED ON MUE EDITING**	**B5**	Coverage-program guidelines were not met or were exceeded.		**No Mapping Required**	**454**	Procedure code for services rendered.
9953	**PAYMENT OF PROCEDURE IS DENIED BASED ON MUE EDITING**	**B5**	Coverage-program guidelines were not met or were exceeded.		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge
9954	**PAYMENT OF PROCEDURE CODE IS DENIED BASED ON CORRECT CODING STANDARDS EDITING**	**B5**	Coverage-program guidelines were not met or were exceeded.		**No Mapping Required**	**454**	Procedure code for services rendered.
9954	**PAYMENT OF PROCEDURE CODE IS DENIED BASED ON CORRECT CODING STANDARDS EDITING**	**B5**	Coverage-program guidelines were not met or were exceeded.		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge
9955	**Claim recouped based on CCI eding**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**101**	Claim was processed as adjustment to previous claim.
9956	**Detail recouped based on CCI editing**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment.	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient.	**101**	Claim was processed as adjustment to previous claim.
9957	**Payment of procedure code is denied based on Correct Coding Standards editing regarding duplicates**	**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.
9958	**Basic personal care service is not allowed for the same DOS as enhanced personal care service.**	**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.

9959	**Enhanced personal care service are not allowed for the same DOS as basic personal care service. Basic personal care service recouped.**	**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.
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.
9961	**Claim recouped based on Correct Coding Standards Duplicate Editing**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**101**	Claim was processed as adjustment to previous claim
9962	**Detail recouped based on Correct Coding Standards Duplicate Editing**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**101**	Claim was processed as adjustment to previous claim
9963	**Claim recouped based on Correct Coding Standards Evaluation and Management Editing**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**101**	Claim was processed as adjustment to previous claim
9964	**Detail recouped based on Correct Coding Standards Evaluation and Management Editing**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**101**	Claim was processed as adjustment to previous claim
9965	**Claim recouped based on Correct Coding Standards Global Surgery Editing**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**101**	Claim was processed as adjustment to previous claim

9966	**Detail recouped based on Correct Coding Standards Global Surgery Editing**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**101**	Claim was processed as adjustment to previous claim
9967	**Claim recouped based on Correct Coding Standards New Visit Editing**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**101**	Claim was processed as adjustment to previous claim
9968	**Detail recouped based on Correct Coding Standards New Visit Editing**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**101**	Claim was processed as adjustment to previous claim
9969	**Claim recouped based on Correct Coding Standards Obstetric Care Editing**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**101**	Claim was processed as adjustment to previous claim
9970	**Detail recouped based on Correct Coding Standards Obstetric Care Editing**	**B13**	Previously paid. Payment for this claim-service may have been provided in a previous payment	**M80**	Not covered when performed during the same session-date as a previously processed service for the patient	**101**	Claim was processed as adjustment to previous claim
9972	**OVER THE COUNTER DRUGS (EXCEPT INSULIN) ARE NOT PAID FOR LONG TERM CARE (SNF ONLY) RECIPIENTS**	**96**	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**M16**	**Alert-** Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision.	**585**	Denied Charge or Non-covered Charge
9972	**OVER THE COUNTER DRUGS (EXCEPT INSULIN) ARE NOT PAID FOR LONG TERM CARE (SNF ONLY) RECIPIENTS**	**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.	**585**	Denied Charge or Non-covered Charge
9973	**LEVULAN DERASTICK, 1 STICK EQUALS 1 UNIT. MEDICAID ALLOWED 2 UNITS WITHIN 8 WEEKS. UNITS CUTBACK TO MAXIMUM ALLOWABLE**	**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.

9973	**LEVULAN DERASTICK, 1 STICK EQUALS 1 UNIT. MEDICAID ALLOWED 2 UNITS WITHIN 8 WEEKS. UNITS CUTBACK TO MAXIMUM ALLOWABLE**	**119**	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.
9973	**LEVULAN DERASTICK, 1 STICK EQUALS 1 UNIT. MEDICAID ALLOWED 2 UNITS WITHIN 8 WEEKS. UNITS CUTBACK TO MAXIMUM ALLOWABLE**	**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
9973	**LEVULAN DERASTICK, 1 STICK EQUALS 1 UNIT. MEDICAID ALLOWED 2 UNITS WITHIN 8 WEEKS. UNITS CUTBACK TO MAXIMUM ALLOWABLE**	**119**	Benefit maximum for this time period or occurrence has been reached	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**483**	Maximum coverage amount met or exceeded for benefit period
9974	**Payment of procedure code is denied based on Correct Coding Standards Add-on Editing**	**B5**	Coverage-program guidelines were not met or were exceeded		**No Mapping Required**	**454**	Procedure code for services rendered
9974	**Payment of procedure code is denied based on Correct Coding Standards Add-on Editing**	**B5**	Coverage-program guidelines were not met or were exceeded		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge
9975	**Payment of procedure code is denied based on Correct Coding Standards Evaluation and Management Crosswalk Editing**	**B5**	Coverage-program guidelines were not met or were exceeded		**No Mapping Required**	**454**	Procedure code for services rendered
9975	**Payment of procedure code is denied based on Correct Coding Standards Evaluation and Management Crosswalk Editing**	**B5**	Coverage-program guidelines were not met or were exceeded		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge
9976	**Payment of procedure code is denied based on Correct Coding Standards Obstetric Editing**	**B5**	Coverage-program guidelines were not met or were exceeded		**No Mapping Required**	**454**	Procedure code for services rendered

9976	**Payment of procedure code is denied based on Correct Coding Standards Obstetric Editing**	**B5**	Coverage-program guidelines were not met or were exceeded		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge
9977	**Payment of procedure code is denied based on Correct Coding Standards Global Surgery Editing**	**B5**	Coverage-program guidelines were not met or were exceeded		**No Mapping Required**	**454**	Procedure code for services rendered
9977	**Payment of procedure code is denied based on Correct Coding Standards Global Surgery Editing**	**B5**	Coverage-program guidelines were not met or were exceeded		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge
9978	**Payment of procedure code is denied based on Correct Coding Standard Age/Gender Editing**	**B5**	Coverage-program guidelines were not met or were exceeded		**No Mapping Required**	**454**	Procedure code for services rendered
9978	**Payment of procedure code is denied based on Correct Coding Standard Age/Gender Editing**	**B5**	Coverage-program guidelines were not met or were exceeded		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge
9979	**Payment of procedure code is denied based on Correct Coding Standards New Visit Editing**	**B5**	Coverage-program guidelines were not met or were exceeded		**No Mapping Required**	**454**	Procedure code for services rendered
9979	**Payment of procedure code is denied based on Correct Coding Standards New Visit Editing**	**B5**	Coverage-program guidelines were not met or were exceeded		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge
9980	**Payment procedure code is denied based on correct coding standards editing regarding facility duplicates**	**B5**	Coverage-program guidelines were not met or were exceeded		**No Mapping Required**	**454**	Procedure code for services rendered
9980	**Payment procedure code is denied based on correct coding standards editing regarding facility duplicates**	**B5**	Coverage-program guidelines were not met or were exceeded		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge
9985	**EXCEEDS MONTHLY PRESCRIPTION LIMIT**	**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	**216**	Drug information.

9985	**EXCEEDS MONTHLY PRESCRIPTION LIMIT**	**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.
9985	**EXCEEDS MONTHLY PRESCRIPTION LIMIT**	**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
9986	**ONLY 8 PRESCRIPTIONS ALLOWED PER MONTH**	**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	**216**	Drug information.
9986	**ONLY 8 PRESCRIPTIONS ALLOWED PER MONTH**	**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.
9986	**ONLY 8 PRESCRIPTIONS ALLOWED PER MONTH**	**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
9987	**MAXIMUM OF 11 PRESCRIPTIONS ALLOWED PER MONTH**	**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	**216**	Drug information.
9987	**MAXIMUM OF 11 PRESCRIPTIONS ALLOWED PER MONTH**	**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.
9987	**MAXIMUM OF 11 PRESCRIPTIONS ALLOWED PER MONTH**	**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
9988	**PAYMENT OF PROCEDURE CODE IS DENIED BASED ON CCI EDITING**	**B5**	Coverage-program guidelines were not met or were exceeded.		**No Mapping Required**	**454**	Procedure code for services rendered.
9988	**PAYMENT OF PROCEDURE CODE IS DENIED BASED ON CCI EDITING**	**B5**	Coverage-program guidelines were not met or were exceeded.		**No Mapping Required**	**585**	Denied Charge or Non-covered Charge

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

9992	**NDC MISSING. VERIFY AND ENTER THE CORRECT NDC AND SUBMIT AS A NEW CLAIM**	**A1**	Claim-Service denied	**M119**	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	**218**	NDC number.
9992	**NDC MISSING. VERIFY AND ENTER THE CORRECT NDC AND SUBMIT AS A NEW CLAIM**	**A1**	Claim-Service denied	**N142**	The original claim was denied. Resubmit a new claim, not a replacement claim	**218**	NDC number.
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.
9995	**Manual price- payment reduced because compound includes non-covered IV solutions (500 MLS or greater) for patients in ICF or SNF. Nursing home should be billed, not Medicaid.**	**109**	Claim not covered by this payer-contractor. You must send the claim to the correct payer-contractor.	**N45**	Payment based on authorized amount.	**64**	Re-pricing information.

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.