

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
4	Provider number missing or invalid. Enter corrected provider number on the claim and submit as a new claim	125	Submission-billing error(s)	N77	Missing-incomplete-invalid designated provider number.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
4	Provider number missing or invalid. Enter corrected provider number on the claim and submit as a new claim	125	Submission-billing error(s)	N77	Missing-incomplete-invalid designated provider number.	132	Entitys Medicaid provider id. Note- This code requires use of an Entity Code.
6	Patient liability/deductible reduced payable amount	142	Monthly Medicaid patient liability amount.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	98	Charges applied to deductible.
8	Paid per medical consultant review	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N10	Claim-service adjusted based on the findings of a review organization-professional consult-manual adjudication-medical or dental advisor.	65	Claim-line has been paid.
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	Entity's National Provider Identifier (NPI)
14	Service denied per medical consultant review	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N10	Claim-service adjusted based on the findings of a review organization-professional consult-manual adjudication-medical or dental advisor.	297	Medical notes/report.
15	Payment reflects DME proration	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.

17	Adjustment request denied as beyond time limit	29	The time limit for filing has expired.	N10	<b>Alert-</b> 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 submitted to the HP Provider Service Unit	29	The time limit for filing has expired.	N10	<b>Alert-</b> 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	<b>Procedure denied for patient over 21 years old</b>	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	<b>Ventilator care not payable to this provider type</b>	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	25	Entity not approved.
27	<b>Dianosis code missing or invalid. Verify and enter the correct diagnosis code and submit as a new claim</b>	146	Diagnosis was invalid for the date(s) of service reported.	M76	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
27	<b>Dianosis code missing or invalid. Verify and enter the correct diagnosis code and submit as a new claim</b>	146	Diagnosis was invalid for the date(s) of service reported.	M76	255	Diagnosis code.
27	<b>Dianosis code missing or invalid. Verify and enter the correct diagnosis code and submit as a new claim</b>	146	Diagnosis was invalid for the date(s) of service reported.	M76	477	Diagnosis code pointer is missing or invalid.
28	<b>Payment include in dialysis charge</b>	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	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	Partially 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	<b>Please indicate Part B Medicare payment in Form Locator 54 and resubmit as a new claim</b>	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	<b>Claim/procedure denied, services not rendered</b>	115	Procedure postponed-canceled-or delayed.		<b>No Mapping Required</b>	585	Denied Charge or Non-covered Charge
37	<b>Detail line not adjusted</b>	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement		<b>No Mapping Required</b>	247	Line information.
37	<b>Detail line not adjusted</b>	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement		<b>No Mapping Required</b>	530	Claim Adjustment Indicator
39	<b>Medicare denied, no coinsurance or deductible or Medicaid payment due</b>	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	<b>Medicare denied, no coinsurance or deductible or Medicaid payment due</b>	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	<b>Admission date/date of service missing or invalid. Verify and enter correct DOS and submit as a new claim</b>	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	<b>Admission date/date of service missing or invalid. Verify and enter correct DOS and submit as a new claim</b>	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).

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.
51	Claim split to facilitate processing	125	Submission-billing error(s)	MA15	<b>Alert-</b> Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported	72	Claim contains split payment.

52	Office and/clinician visit includes payment for service	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	454	Procedure code for services rendered.
53	Payment included in daily care	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	454	Procedure code for services rendered.
55	Service included in the fee for visual aid	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	454	Procedure code for services rendered.
56	Office visit included in Fee for Service	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	454	Procedure code for services rendered.
58	Service dates prior to admission date. Verify admit date and DOS. Correct and rebill as a new claim	125	Submission-billing error(s)	MA31	Missing-incomplete-invalid beginning and ending dates of the period billed.	187	Date(s) of service.

58	<b>Service dates prior to admission date. Verify admit date and DOS. Correct and rebill as a new claim</b>	125	Submission-billing error(s)	MA31	Missing-incomplete-invalid beginning and ending dates of the period billed.	189	Facility admission date
59	<b>Adjustments equal to or less than on dollar denied</b>	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	<b>Not in accordance with Medical Policy guidelines</b>	B5	Coverage-program guidelines were not met or were exceeded.		<b>No Mapping Required</b>	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
61	<b>Full recoument, bill Medicare</b>	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	<b>Durable medical equipment guidelines not met</b>	108	Rent-purchase guidelines were not met. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present		<b>No Mapping Required</b>	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
63	<b>Correct assistan surgeons claim using TOS 08 in Field 24C of the CMS 1500 Claim Form and resubmit as a new claim</b>	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	<b>Correct assistant surgeons claim using TOS 08 in Field 24C of the CMS 1500 Claim Form and resubmit as a new claim</b>	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	481	Claim submission format is invalid.
67	<b>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</b>	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.
69	<b>Bill Medicare Part A Carrier</b>	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	116	Claim submitted to incorrect payer.
72	<b>Similar item previously rented or purchased</b>	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 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	<b>Similar item previously rented or purchased</b>	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 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.
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
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.

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.
83	Exceeds legislative limits	119	Benefit maximum for this time period or occurrence has been reached.	N130	<b>Alert-</b> 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		<b>No Mapping Required</b>	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		<b>No Mapping Required</b>	88	Entity not eligible for benefits for submitted dates of service.
85	Attending provider ID is missing, invalid, or unresolved. Verify attending provider ID and resubmit as a new claim or contact HP Provider Services if ID is correct	A1	Claim-Service denied	N253	Missing-incomplete-invalid attending provider primary identifier.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
85	Attending provider ID is missing, invalid, or unresolved. Verify attending provider ID and resubmit as a new claim or contact HP Provider Services if ID is correct	A1	Claim-Service denied	N253	Missing-incomplete-invalid attending provider primary identifier.	562	Entity's National Provider Identifier (NPI)

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

117	Denied for deductible	A1	Claim-Service denied	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	98	Charges applied to deductible.
118	Claim denied due to eligibility issue, resubmit claim to DMA Claims Analysis Unit	31	Patient cannot be identified as our insured	N142	The original claim was denied. Resubmit a new claim, not a replacement claim.	56	Awaiting eligibility determination.
119	Adjustment paid correctly per Medicaid guidelines	B13	Previously paid. Payment for this claim-service may have been provided in a previous payment.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.
119	Adjustment paid correctly per Medicaid guidelines	B13	Previously paid. Payment for this claim-service may have been provided in a previous payment.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	101	Claim was processed as adjustment to previous claim.
120	Recipient MID number missing. Enter MID and submit as a new claim	125	Submission-billing error(s)	MA61	Missing-incomplete-invalid social security number or health insurance claim number.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
120	Recipient MID number missing. Enter MID and submit as a new claim	125	Submission-billing error(s)	MA61	Missing-incomplete-invalid social security number or health insurance claim number.	478	Claim submitters identifier (patient account number) is missing.
121	Refile this claim and EOMB - system	A1	Claim-Service denied	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	481	Claim-submission format is invalid.
122	Dates of service before prior approval date. Verify DOS and PA number; correct and submit as a new claim	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	84	Service not authorized.

122	Dates of service before prior approval date. Verify DOS and PA number; correct and submit as a new claim	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	187	Date(s) of service.
123	Dates of service after prior approval DOS and PA number; correct and submit as new claim	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	84	Service not authorized.
123	Dates of service after prior approval DOS and PA number; correct and submit as new claim	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	187	Date(s) of service.
124	Exceeds state dental limitation	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum	259	Frequency of service.
125	Previously paid on claim - system	18	Exact duplicate claim-service	M86	Service denied because payment already made for same-similar procedure within set time frame.	259	Frequency of service.
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.
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	<b>Paid as billed per Department of Health Services review</b>	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	<b>N381</b>	Consult our contractual agreement for restrictions-billing-payment information related to these charges	<b>65</b>	Claim-line has been paid.
152	<b>Paid as billed per Department of Health Services review</b>	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	<b>N381</b>	Consult our contractual agreement for restrictions-billing-payment information related to these charges	<b>107</b>	Processed according to contract-plan provisions.
153	<b>Ancillary charges included in per diem rate</b>	125	Submission-billing error(s)	<b>M2</b>	Not paid separately when the patient is an inpatient.	<b>21</b>	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
155	<b>Medicare denied ambulance service not covered by Medicaid</b>	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N381</b>	Consult our contractual agreement for restrictions-billing-payment information related to these charges	<b>454</b>	Procedure code for services rendered.
156	<b>Laboratory revenue code requires corresponding lab CPT code. Enter CPT code and resubmit as a new claim</b>	125	Submission-billing error(s)	<b>M51</b>	Missing-incomplete-invalid procedure code(s).	<b>454</b>	Procedure code for services rendered.
156	<b>Laboratory revenue code requires corresponding lab CPT code. Enter CPT code and resubmit as a new claim</b>	125	Submission-billing error(s)	<b>M51</b>	Missing-incomplete-invalid procedure code(s).	<b>455</b>	Revenue code for services rendered.
157	<b>Late discharge non covered by Medicaid</b>	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N50</b>	Missing-incomplete-invalid discharge information.	<b>457</b>	Non-Covered Day(s)
158	<b>This revenue code requires a CPT laboratory procedure code</b>	125	Submission-billing error(s)	<b>M51</b>	Missing-incomplete-invalid procedure code(s).	<b>454</b>	Procedure code for services rendered.
158	<b>This revenue code requires a CPT laboratory procedure code</b>	125	Submission-billing error(s)	<b>M51</b>	Missing-incomplete-invalid procedure code(s).	<b>455</b>	Revenue code for services rendered.
159	<b>Rebill for non-waiver services on an approved UB claim form</b>	125	Submission-billing error(s)	<b>N34</b>	Incorrect claim form-format for this service.	<b>228</b>	Type of bill for UB claim

161	Report does not justify higher fee	150	Payer deems the information submitted does not support this level of service		No Mapping Required	297	Medical notes/report.
162	Indicate date of delivery, name of delivering physician and date patient was first seen for condition	125	Submission-billing error(s)	MA31	Missing-incomplete-invalid beginning and ending dates of the period billed.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
162	Indicate date of delivery, name of delivering physician and date patient was first seen for condition	125	Submission-billing error(s)	MA31	Missing-incomplete-invalid beginning and ending dates of the period billed.	192	Date of first service for current series-symptom-illness.
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.
168	BILLED AMOUNT REDUCED BY NON-COVERED CHARGE	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M79	Missing-incomplete-invalid charge	454	Procedure code for services rendered.
169	BILLED AMOUNT EQUAL TO NON-COVERED CHARGE	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M79	Missing-incomplete-invalid charge	178	Submitted charges.
169	BILLED AMOUNT EQUAL TO NON-COVERED CHARGE	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M79	Missing-incomplete-invalid charge	454	Procedure code for services rendered.
169	BILLED AMOUNT EQUAL TO NON-COVERED CHARGE	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M79	Missing-incomplete-invalid charge	596	Non-covered Charge Amount.

173	<b>TRANSPORTATION NOT TO THE NEAREST APPROPRIATE FACILITY. PLEASE RESUBMIT AN ADJUSTMENT WITH DOCUMENTATION TO JUSTIFY TRANSPORT TO THIS FACILITY</b>	117	Transportation is only covered to the closest facility that can provide the necessary care	<b>N157</b>	Transportation to-from this destination is not covered.	<b>101</b>	Claim was processed as adjustment to previous claim.
173	<b>TRANSPORTATION NOT TO THE NEAREST APPROPRIATE FACILITY. PLEASE RESUBMIT AN ADJUSTMENT WITH DOCUMENTATION TO JUSTIFY TRANSPORT TO THIS FACILITY</b>	117	Transportation is only covered to the closest facility that can provide the necessary care	<b>N157</b>	Transportation to-from this destination is not covered.	<b>430</b>	Nearest appropriate facility.
174	<b>SERVICE DATE MUST BE SAME AS BIRTHDATE WITH UNIT OF 1</b>	125	Submission-billing error(s)	<b>M53</b>	Missing-incomplete-invalid days or units of service.	<b>187</b>	Date(s) of service.
174	<b>SERVICE DATE MUST BE SAME AS BIRTHDATE WITH UNIT OF 1</b>	125	Submission-billing error(s)	<b>MA31</b>	Missing-incomplete-invalid beginning and ending dates of the period billed.	<b>187</b>	Date(s) of service.
175	<b>ADMIT HOUR REQUIRED ON OUTPATIENT CLAIM FORMAT</b>	125	Submission-billing error(s)	<b>N46</b>	Missing-incomplete-invalid admission hour.	<b>21</b>	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
176	<b>REFILE ON THE APPROVED UB CLAIM FORMAT USING THE CORRECT BILL TYPE</b>	125	Submission-billing error(s)	<b>MA30</b>	Missing-incomplete-invalid type of bill.	<b>228</b>	Type of bill for UB claim.
176	<b>REFILE ON THE APPROVED UB CLAIM FORMAT USING THE CORRECT BILL TYPE</b>	125	Submission-billing error(s)	<b>MA30</b>	Missing-incomplete-invalid type of bill.	<b>276</b>	UB04-HCFA-1450-1500 claim form
177	<b>MULTIPLE PROVIDERS MAY NOT BILL ON SAME CLAIM FORM; RESUBMIT WITH ONE PROVIDER PER CLAIM FORM</b>	125	Submission-billing error(s)	<b>N61</b>	Rebill services on separate claims.	<b>21</b>	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

178	<b>PURCHASE OF VACCINE NOT INDICATED ON EPSDT CLAIM. IMMUNIZATION PAID TO DHS</b>	23	The impact of prior payer(s) adjudication including payments and-or adjustments		<b>No Mapping Required</b>	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
178	<b>PURCHASE OF VACCINE NOT INDICATED ON EPSDT CLAIM. IMMUNIZATION PAID TO DHS</b>	23	The impact of prior payer(s) adjudication including payments and-or adjustments		<b>No Mapping Required</b>	107	Processed according to contract-plan provisions.
179	<b>SERVICE COVERED BY HMO</b>	24	Charges are covered under a capitation agreement-managed care plan		<b>No Mapping Required</b>	96	No agreement with entity.
179	<b>SERVICE COVERED BY HMO</b>	24	Charges are covered under a capitation agreement-managed care plan		<b>No Mapping Required</b>	585	Denied Charge or Non-covered Charge
180	<b>MONITOR EQUIPMENT NOT PAYABLE WHEN PATIENT IN ICU/CCU</b>	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service 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	<b>REFILE ON OPTICAL CLAIM FORM</b>	125	Submission-billing error(s)	N34	Incorrect claim form-format for this service.	481	Claim-submission format is invalid.
182	<b>ALL CLAIMS SUSPENDED PENDING FINANCIAL REVIEW. CONTACT HP PROVIDER SERVICES 1-800-688-6696</b>	133	The disposition of this claim-service is pending further review.	N187	<b>Alert-</b> 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	<b>REFILE ON HOME HEALTH CLAIM FORMAT</b>	125	Submission-billing error(s)	N34	Incorrect claim form-format for this service.	481	Claim-submission format is invalid.

185	REBILL SERVICE USING APPROPRIATE CODE FOR DOSAGE	153	Payer deems the information submitted does not support this dosage	M123	Missing-incomplete-invalid name, strength, or dosage of the drug furnished.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
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.
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
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	<b>A HANDWRITTEN OR STAMPED PROVIDER SIGNATURE REQUIRED</b>	125	Submission-billing error(s)	<b>MA81</b>	Missing-incomplete-invalid provider-supplier signature	<b>466</b>	Entities original signature. Note This code requires use of an Entity Code. This change effective 11-1-2011- Entitys Original Signature. Note- This code requires use of an Entity Code.
210	<b>PAYEMENT DENIED; THERE IS NOT EVIDENCE THAT PRESENT INSTITUTION DOES NOT HAVE APPROPRIATED MEDICAL FACILITIES FOR PATIENTS TX</b>	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		<b>No Mapping Required</b>	<b>344</b>	Documentation that provider of physical therapy is Medicare Part B approved.
212	<b>DISPROPORTIONATE SHARE HOSPITAL PAYMENT INCREASE OF 5% FOR CHILDREN UNDER AGE 1 WITH CHARGES GREATER THAN ANNUAL MAXIMUM OR STAYS OVER 65 DAYS</b>	119	Benefit maximum for this time period or occurrence has been reached.		<b>No Mapping Required</b>	<b>259</b>	Frequency of service.
213	<b>NO UPIN ON CLAIM. REFILE WITH CORRECT UPIN</b>	197	Precertification-authorization-notification absent.	<b>N54</b>	Claim information is inconsistent with pre-certified-authorized services.	<b>84</b>	Service not authorized
215	<b>SEND COPY OF CLAI, CERTIFICATION OF NEED AND RA TO DMA, PROGRAM INTEGRITY, INPATIENT PSYCHIATRIC, 2515 MAIL SERVICE CENTER, RALEIGH, NC 27699-2515</b>	16	Claim-service lacks information which is needed for adjudication	<b>N29</b>	Missing documentation-orders-notes-summary-report-chart.	<b>287</b>	Medical necessity for service.
217	<b>CODE PERTAINS TO PHYSICIAN ESCORT ONLY. IF BILLING FOR PHYSICIAN ESCORT, PLEASE NOTE TO AND FROM DESTINATIONS AND TIME INVOLVED</b>	16	Claim-service lacks information which is needed for adjudication	<b>N225</b>	Incomplete-invalid documentation-orders-notes-summary-report-chart.	<b>21</b>	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

219	INDICATE NUMBER OF MILES OUTSIDE BASE AND/OR COST/MILE	125	Submission-billing error(s)	M22	Missing-incomplete-invalid number of miles traveled.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
219	INDICATE NUMBER OF MILES OUTSIDE BASE AND/OR COST/MILE	125	Submission-billing error(s)	M22	Missing-incomplete-invalid number of miles traveled.	267	Number of miles patient was transported.
221	A NEW PRIOR APPROVAL REQUEST MUST BE SUBMITTED FOR ADDITIONAL UNITS	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	84	Service not authorized.
221	A NEW PRIOR APPROVAL REQUEST MUST BE SUBMITTED FOR ADDITIONAL UNITS	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	258	Days-units for procedure-revenue code.
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.
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	<b>THE HYSTERECTOMY STATEMENT DOES NOT MEET FEDERAL GUIDELINES, RESUBMIT A COMPLETED NEW 'PRIOR TO MY SURGERY' STATEMENT</b>	16	Claim-service lacks information which is needed for adjudication	N3	Missing consent form.	297	Medical notes/report.
227	<b>THIS SERVICE REQUIRES PRIOR APPROVAL FOR YOUR PROVIDER NUMBER</b>	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	84	Service not authorized.
232	<b>PSYCHOSOCIAL REHAD NOT ALLOWED SAME DOS AS OLD PSYCH REHAB PROCEDURE</b>	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service 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	<b>INTERPRETATION AND/OR PROFESSIONAL COMPONENT IS INLUCED IN FEE FOR SERVICE</b>	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 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.
235	<b>SERVUCE DENIED, RECIPIENTS SIGNATURE AND-OR SIGNATURE DATE ON STERILIZATION CONSENT FORM HAS BEEN ALTERED</b>	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	<b>SERVUCE DENIED, RECIPIENTS SIGNATURE AND-OR SIGNATURE DATE ON STERILIZATION CONSENT FORM HAS BEEN ALTERED</b>	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.
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

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.
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
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 ( <b>Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services</b> )
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.
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.
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	<b>Alert-</b> 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	<b>Alert-</b> 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.
272	ADJUSTMENT REQUEST DENIED, ADJUSTMENTS ARE NOT PROCESSED FOR RATE CHANGES	138	Appeal procedures not followed or time limits not met	M51	Missing-incomplete-invalid procedure code(s).	101	Claim was processed as adjustment to previous claim.
273	FULL RECOUPMENT, PER YOUR REQUEST	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.
275	FULL RECOUPMENT, CLAIM HAS BEEN SUBMITTED	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.
277	FULL RECOUPMENT, PAID FOR WRONG RECIPIENT	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.
278	FULL RECOUPMENT, PAID FOR WRONG RECIPIENT	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.

279	<b>NO PATIENT LIABILITY ON ELIG FILE</b>	142	Monthly Medicaid patient liability amount.	<b>N58</b>	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	<b>FULL RECOUPMENT PER MEDICAL OR POLICY REVIEW</b>	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	<b>MA67</b>	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.
281	<b>FULL RECOUPMENT, DUPLICATE PAYMENT</b>	18	Exact duplicate claim-service	<b>M86</b>	Service denied because payment already made for same-similar procedure within set time frame.	54	Duplicate of a previously processed claim-line.
282	<b>PATIENT STATUS MISSING OR INVALID</b>	125	Submission-billing error(s)	<b>MA43</b>	Missing-incomplete-invalid patient status.	18	Entity received claim-encounter, but returned invalid status.
282	<b>PATIENT STATUS MISSING OR INVALID</b>	125	Submission-billing error(s)	<b>MA43</b>	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.
284	<b>DISPENSING DATE IS BEFORE NDC NUMBER WAS PACED ON MARKET</b>	B5	Coverage-program guidelines were not met or were exceeded.		<b>No Mapping Required</b>	107	Processed according to contract-plan provisions.
285	<b>ADJUSTMENT DENIED-CHANGE IN PATIENT LIABILITY SHOULD HAVE BEEN ON CLAIM BEFORE SUBMISSION</b>	125	Submission-billing error(s)	<b>N58</b>	Missing-incomplete-invalid patient liability amount.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
287	<b>ADJUSTMENT DENIED, REFERENCE ONLY ONE CLAIM PER FORM. REFILE ADJSUTMENTS SEPERATELY</b>	125	Submission-billing error(s)	<b>N1</b>	<b>Alert</b> - 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 ADJUSTMENTS SEPARATELY	125	Submission-billing error(s)	N61	Rebill services on separate claims.	101	Claim was processed as adjustment to previous claim.
288	ADJUSTMENT DENIED; DMA FILES INDICATE COMMERCIAL INSURANCE. REFILE WITH INSURANCE PAYMENT/DENIAL VOUCHER	148	Information from another provider was not provided or was insufficient-incomplete	N61	Rebill services on separate claims.	275	Claim
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.
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	<b>Alert-</b> 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	<b>Alert-</b> Do not resubmit this claim-service	72	Claim contains split payment.
297	CLAIM DENIED- WILL BE PAID AS A FINANCIAL ITEM ON FUTURE REMITTANCE ADVICE	101	Predetermination: anticipated payment upon completion of services or claim adjudication.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	3	Claim has been adjudicated and is awaiting payment cycle.
298	CATASTROPHIC PROVIDERS MUST INDICATE MEDICARE PAYMENTS FOR SERVICES TO CATASTROPHIC RECIPIENTS, EITHER AS CROSSOVER IF DOS IS PRIOR TO 10-1-02 OR THIRD PARTY IF 10/1/02 OR AFTER	109	Claim not covered by this payer-contractor. You must send the claim to the correct payer-contractor.	N95	This provider type - provider specialty may not bill this service.	91	Entity not eligible-not approved for dates of service.
302	PAYMENT REDUCED BY NEGATIVE MEDICARE REIMBURSEMENT	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	107	Processed according to contract-plan provisions.

302	PAYMENT REDUCED BY NEGATIVE MEDICARE REIMBURSEMENT	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.
309	SERVICE IS INCLUDED IN CORE	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	454	Procedure code for services rendered.
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.
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	<b>PROCEDURE, PROCEDURE-MODIFIER COMBINATION OR RATE NOT COVERED FOR THIS DATE OF SERVICE</b>	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N301</b>	Missing-incomplete-invalid procedure date(s).	<b>454</b>	Procedure code for services rendered.
326	<b>A VALID DATE OF DENIAL MUST ACCOMPANY OCCURRENCE CODE 24. CORRECT AND RESUBMIT AS A NEW CLAIM</b>	125	Submission-billing error(s)	<b>MA130</b>	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	<b>21</b>	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
326	<b>A VALID DATE OF DENIAL MUST ACCOMPANY OCCURRENCE CODE 24. CORRECT AND RESUBMIT AS A NEW CLAIM</b>	125	Submission-billing error(s)	<b>MA130</b>	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	<b>721</b>	NUBC Occurrence Span Code(s)
326	<b>A VALID DATE OF DENIAL MUST ACCOMPANY OCCURRENCE CODE 24. CORRECT AND RESUBMIT AS A NEW CLAIM</b>	125	Submission-billing error(s)	<b>MA130</b>	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	<b>722</b>	NUBC Occurrence Span Code Date(s)
327	<b>CODE MULTIPLE LAB TEST ON THE SAME DAY TO EQUIVALENT PANEL CODE</b>	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient.	<b>454</b>	Procedure code for services rendered.
356	<b>MAPPED ATTENDING PROVIDER ID IS NOT ELIBIBLE ON SERVICE DATE</b>	A1	Claim-Service denied	<b>N253</b>	Missing-incomplete-invalid attending provider primary identifier.	<b>91</b>	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)
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	<b>Alert-</b> 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.
423	ONLY ONE IMPATIENT GENERAL CARE 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
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.
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	<b>Alert-</b> Do not resubmit this claim-service	297	Medical notes/report.
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.
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.

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.
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 outpatient 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.
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.
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.
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	<b>Suspect duplicate, overlapping dates of service inst.</b>	18	Exact duplicate claim-service	<b>M86</b>	Service denied because payment already made for same-similar procedure within set time frame.	54	Duplicate of a previously processed claim-line.
473	<b>NURSING HOME DAYS DENIED OR RECOUPED TO PAY INPATIENT HOSPITAL DAYS</b>	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M2</b>	Not paid separately when the patient is an inpatient.	258	Days-units for procedure-revenue code.
473	<b>NURSING HOME DAYS DENIED OR RECOUPED TO PAY INPATIENT HOSPITAL DAYS</b>	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M86</b>	Service denied because payment already made for same-similar procedure within set time frame.	258	Days-units for procedure-revenue code.
475	<b>Suspect dupe-exact service date, prof sys plug.</b>	18	Exact duplicate claim-service	<b>M86</b>	Service denied because payment already made for same-similar procedure within set time frame.	54	Duplicate of a previously processed claim-line.
476	<b>SUSPECT DUPE PROF SYS PLUG</b>	18	Exact duplicate claim-service	<b>M86</b>	Service denied because payment already made for same-similar procedure within set time frame.	54	Duplicate of a previously processed claim-line.
477	<b>SUSPECT DUPE PROF SYS PLUG</b>	18	Exact duplicate claim-service	<b>M86</b>	Service denied because payment already made for same-similar procedure within set time frame.	54	Duplicate of a previously processed claim-line.
479	<b>SUSPECT DUPE PROF SYS PLUG</b>	18	Exact duplicate claim-service	<b>M86</b>	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.
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.
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.

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.
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.
517	Duplicate charges DOS billed by CAP 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.
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.
534	Copay previously deducted for this date of service.	3	Co-payment Amount		No Mapping Required	104	Processed according to plan provisions.
538	Procedure not allowed in conjunction with general anesthesia.	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N203	Service not payable with other service rendered on the same date.	258	Days-units for procedure-revenue code.
549	Service denied: exceeds limit of 4 billings 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.

550	EXCEEDS MAXIMUM OF 12 UNITS PER CALENDAR WEEK	119	Benefit maximum for this time period or occurrence has been reached.	N357	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	259	Frequency of service.
550	EXCEEDS MAXIMUM OF 12 UNITS PER CALENDAR WEEK	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum	259	Frequency of service.
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	<b>OTHER DIAGNOSIS CODE 4 MUST BE FURTHER SUBDIVIDED. (THE CODE MUST HAVE FOUR OR FIVE DIGITS)</b>	146	Diagnosis was invalid for the date(s) of service reported.	<b>M64</b>	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	<b>OTHER DIAGNOSIS CODE 4 MUST BE FURTHER SUBDIVIDED. (THE CODE MUST HAVE FOUR OR FIVE DIGITS)</b>	146	Diagnosis was invalid for the date(s) of service reported.	<b>M64</b>	Missing-incomplete-invalid other diagnosis.	255	Diagnosis code.
560	<b>OTHER DIAGNOSIS CODE 5 MUST BE FURTHER SUBDIVIDED</b>	146	Diagnosis was invalid for the date(s) of service reported.	<b>M64</b>	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	<b>OTHER DIAGNOSIS CODE 5 MUST BE FURTHER SUBDIVIDED</b>	146	Diagnosis was invalid for the date(s) of service reported.	<b>M64</b>	Missing-incomplete-invalid other diagnosis.	255	Diagnosis code.
569	<b>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</b>	197	Precertification-authorization-notification absent.	<b>N54</b>	Claim information is inconsistent with pre-certified-authorized services.	453	Procedure code modifier(s) for service(s) rendered.
569	<b>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</b>	197	Precertification-authorization-notification absent.	<b>N188</b>	The approved level of care does not match the procedure code submitted.	453	Procedure code modifier(s) for service(s) rendered.

569	<b>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</b>	197	Precertification-authorization-notification absent.	<b>N56</b>	Procedure code billed is not correct-valid for the services billed or the date of service billed.	<b>453</b>	Procedure code modifier(s) for service(s) rendered.
572	<b>SERVICE DENIED; PA HAS NOT BEEN OBTAINED BY THE PRIMARY PHYSICIAN</b>	197	Precertification-authorization-notification absent.	<b>N54</b>	Claim information is inconsistent with pre-certified-authorized services.	<b>48</b>	Referral-authorization.
572	<b>SERVICE DENIED; PA HAS NOT BEEN OBTAINED BY THE PRIMARY PHYSICIAN</b>	197	Precertification-authorization-notification absent.	<b>N54</b>	Claim information is inconsistent with pre-certified-authorized services.	<b>84</b>	Service not authorized.
574	<b>PROCEDURE OR PROCEDURE-MODIFIER COMBINATION IS NOT COVERED FOR THE DATE OF PROCESSING</b>	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>MA66</b>	Missing-incomplete-invalid principal procedure code.	<b>453</b>	Procedure Code Modifier(s) for Service(s) Rendered.
574	<b>PROCEDURE OR PROCEDURE-MODIFIER COMBINATION IS NOT COVERED FOR THE DATE OF PROCESSING</b>	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N301</b>	Missing-incomplete-invalid procedure date(s).	<b>453</b>	Procedure Code Modifier(s) for Service(s) Rendered.
574	<b>PROCEDURE OR PROCEDURE-MODIFIER COMBINATION IS NOT COVERED FOR THE DATE OF PROCESSING</b>	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>MA66</b>	Missing-incomplete-invalid principal procedure code.	<b>457</b>	Non-Covered Day(s).
574	<b>PROCEDURE OR PROCEDURE-MODIFIER COMBINATION IS NOT COVERED FOR THE DATE OF PROCESSING</b>	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N301</b>	Missing-incomplete-invalid procedure date(s).	<b>457</b>	Non-Covered Day(s).
575	<b>PROCEDURE OR PRECEDURE-MODIFIER COMBINATION IS NOT COVERED FOR THE DATE OF RECEIPT</b>	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>MA66</b>	Missing-incomplete-invalid principal procedure code.	<b>453</b>	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).
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.

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	<b>OTHER PROCEDURE CODE 5 IS INVALID</b>	125	Submission-billing error(s)	<b>N56</b>	Procedure code billed is not correct-valid for the services billed or the date of service billed.	<b>490</b>	Other procedure code for service(s) rendered
593	<b>OTHER PROCEDURE CODE 6 IS INVALID</b>	125	Submission-billing error(s)	<b>N56</b>	Procedure code billed is not correct-valid for the services billed or the date of service billed.	<b>21</b>	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
593	<b>OTHER PROCEDURE CODE 6 IS INVALID</b>	125	Submission-billing error(s)	<b>N56</b>	Procedure code billed is not correct-valid for the services billed or the date of service billed.	<b>490</b>	Other procedure code for service(s) rendered.
598	<b>General anesthesia for sterilization billed in conjunction with general anesthesia for delivery is being reimbursed to reflect time only.</b>	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient.	<b>454</b>	Procedure code for services rendered.
607	<b>A VALID DATE IS REQUIRED WITH OCCURRENCE CODE. CORRECT AND RESUBMIT AS A NEW CLAIM</b>	125	Submission-billing error(s)	<b>N299</b>	Missing-incomplete-invalid occurrence date(s).	<b>21</b>	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
607	<b>A VALID DATE IS REQUIRED WITH OCCURRENCE CODE. CORRECT AND RESUBMIT AS A NEW CLAIM</b>	125	Submission-billing error(s)	<b>N299</b>	Missing-incomplete-invalid occurrence date(s).	<b>187</b>	Date(s) of service.
607	<b>A VALID DATE IS REQUIRED WITH OCCURRENCE CODE. CORRECT AND RESUBMIT AS A NEW CLAIM</b>	125	Submission-billing error(s)	<b>N299</b>	Missing-incomplete-invalid occurrence date(s).	<b>720</b>	NUBC Occurrence Code Date(s)

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.
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.
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.
613	Follow-up allowed only twice in a life time.	119	Benefit maximum 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.

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.
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

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.
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
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
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	<b>Alert-</b> 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 present 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.

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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Non-therapeutic abortion must be billed with appropriate diagnosis code. Correct and resubmit.</b>	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	<b>Non-therapeutic abortion must be billed with appropriate diagnosis code. Correct and resubmit.</b>	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	<b>Alert-</b> Please refer to your provider manual for additional program and provider information	488	Diagnosis code(s) for the services rendered.
682	<b>Induced abortion procedure code must be billed with appropriate diagnosis code. Correct and resubmit on pap with records and federal abortion statement</b>	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	<b>Induced abortion procedure code must be billed with appropriate diagnosis code. Correct and resubmit on pap with records and federal abortion statement</b>	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	<b>Alert-</b> 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	<b>Induced abortion procedure code must be billed with appropriate diagnosis code. Correct and resubmit on pap with records and federal abortion statement</b>	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	<b>Induced abortion procedure code must be billed with appropriate diagnosis code. Correct and resubmit on pap with records and federal abortion statement</b>	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	<b>Alert-</b> 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	<b>Alert-</b> 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.
685	Health check services are for Medicaid recipients birth thru age 20 only.	6	The procedure-revenue code is inconsistent with the patients age		<b>No Mapping Required</b>	475	Procedure code not valid for patient age.
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		<b>No Mapping Required</b>	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		<b>No Mapping Required</b>	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.
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	123	Additional information requested from entity.
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.
762	MEDICAL NECESSITY FOR MULTIPLE ULTRASOUNDS NOT APPARENT. RESUBMIT AS ADJUSTMENT WITH RECORDS	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.
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
795	Services recouped. Documentation shows a different provider as admitting-attending physician. Rebill as a consult.	125	Submission-billing error(s)	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.

795	Services recouped. Documentation shows a different provider as admitting-attending physician. Rebill as a consult.	125	Submission-billing error(s)	MA67	Correction to a prior claim.	454	Procedure code for services rendered.
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.
810	Adjustment denied; adjustment can not be processed without corrected information. Refile adjustment with a complete, legible, corrected claim copy.	125	Submission-billing error(s)	N3	Missing consent form.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
810	Adjustment denied; adjustment can not be processed without corrected information. Refile adjustment with a complete, legible, corrected claim copy.	125	Submission-billing error(s)	N3	Missing consent form.	294	Supporting documentation.
811	Adjustment denied, attach copy of recipient Medicaid card for these dates and forward to Division of Medical Assistance, 1985 Umstead Dr. Box 29529 Raleigh NC 27626-0529.	177	Patient has not met the required eligibility requirements.	N30	Patient ineligible for this service.	123	Additional information requested from entity.

812	Adjustment denied, please refile with all related R-A's including original processing.	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes- summary- report- chart.	294	Supporting documentation.
813	This Home Health claim has been adjusted to reflect the rate increase effective 07-01-92.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N144	The rate changed during the dates of service billed.	65	Claim-line has been paid.
813	This Home Health claim has been adjusted to reflect the rate increase effective 07-01-92.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	65	Claim-line has been paid.
813	This Home Health claim has been adjusted to reflect the rate increase effective 07-01-92.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N144	The rate changed during the dates of service billed.	101	Claim was processed as adjustment to previous claim
813	This Home Health claim has been adjusted to reflect the rate increase effective 07-01-92.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	101	Claim was processed as adjustment to previous claim

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

819	Both the 'from' and 'to' date of service must be the date of delivery when billing total ob package or delivery codes.	125	Submission-billing error(s)	MA31	Missing-incomplete-invalid beginning and ending dates of the period billed.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
819	Both the 'from' and 'to' date of service must be the date of delivery when billing total ob package or delivery codes.	125	Submission-billing error(s)	M53	Missing-incomplete-invalid days or units of service.	188	Statement from-through dates.
819	Both the 'from' and 'to' date of service must be the date of delivery when billing total ob package or delivery codes.	125	Submission-billing error(s)	MA31	Missing-incomplete-invalid beginning and ending dates of the period billed.	188	Statement from-through dates.
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.
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.
828	Disproportionate share hospital payment increase of 5% for children under age 6 with charges greater than annual maximum or stays over 65 days.	76	Disproportionate Share Adjustment.		No Mapping Required	104	Processed according to plan provisions.
829	All claims and R-A's related to interim billings must be attached to adjustment request.	16	Claim-service lacks information which is needed for adjudication	N1	<b>Alert-</b> You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
829	All claims and R-A's related to interim billings must be attached to adjustment request.	16	Claim-service lacks information which is needed for adjudication	N3	Missing consent form.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
830	Non-disproportionate share hospital payment increase of 5% for children under age 1 with charges greater than annual maximum or stays over 65 days.	76	Disproportionate Share Adjustment.		No Mapping Required	104	Processed according to plan provisions.
834	This previously paid claim has been recouped and repaid in this check write to include the additional disproportionate share 5%.	76	Disproportionate Share Adjustment.		No Mapping Required	104	Processed according to plan provisions.

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.
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.
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	<b>Alert-</b> 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	<b>Alert-</b> Please refer to your provider manual for additional program and provider information.	297	Medical notes/report.

864	<b>HYSTERECTOMY STATEMENT RECEIVED ILLEGIBLE. RESUBMIT A LEGIBLE STATEMENT</b>	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	<b>HYSTERECTOMY STATEMENT RECEIVED ILLEGIBLE. RESUBMIT A LEGIBLE STATEMENT</b>	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	<b>HYSTERECTOMY STATEMENT RECEIVED ILLEGIBLE. RESUBMIT A LEGIBLE STATEMENT</b>	16	Claim-service lacks information which is needed for adjudication	N3	Missing consent form.	297	Medical notes/report.
864	<b>HYSTERECTOMY STATEMENT RECEIVED ILLEGIBLE. RESUBMIT A LEGIBLE STATEMENT</b>	16	Claim-service lacks information which is needed for adjudication	N205	Information provider was illegible.	297	Medical notes/report.
865	<b>WRONG HYSTERECTOMY STATEMENT SENT. RESUBMIT THE 'PRIOR TO' STATEMENT.</b>	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	<b>WRONG HYSTERECTOMY STATEMENT SENT. RESUBMIT THE 'PRIOR TO' STATEMENT.</b>	16	Claim-service lacks information which is needed for adjudication	N59	<b>Alert-</b> 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	<b>WRONG HYSTERECTOMY STATEMENT SENT. RESUBMIT THE 'PRIOR TO' STATEMENT.</b>	16	Claim-service lacks information which is needed for adjudication	N3	Missing consent form.	297	Medical notes/report.
865	<b>WRONG HYSTERECTOMY STATEMENT SENT. RESUBMIT THE 'PRIOR TO' STATEMENT.</b>	16	Claim-service lacks information which is needed for adjudication	N59	<b>Alert-</b> 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 IDENTIFY 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 IDENTIFY 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 IDENTIFY SIGNATURE AND RESUBMIT	16	Claim-service lacks information which is needed for adjudication	N3	Missing consent form.	297	Medical notes/report.

869	<b>ILLEGIBLE WITNESS AND/OR PATIENT SIGNATURE ON HYSTERECTOMY STATEMENT. PLEASE IDENTIFY SIGNATURE AND RESUBMIT</b>	16	Claim-service lacks information which is needed for adjudication	N205	Information provided was illegible.	297	Medical notes/report.
870	<b>Personal Care Services not allowed the same day as CAP In-Home Level II and In-Home Level III.</b>	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other 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.
875	<b>Full recoup, rebill using the correct type of service.</b>	125	Submission-billing error(s)	MA67	Correction to a prior claim.	250	Type of service.
889	<b>MEDICARE COVERED DAYS ARE MISSING OR INVALID. REFILE PAPER CLAIM WITH MEDICARE EOB</b>	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	<b>MEDICARE COVERED DAYS ARE MISSING OR INVALID. REFILE PAPER CLAIM WITH MEDICARE EOB</b>	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	<b>MEDICARE COVERED DAYS ARE MISSING OR INVALID. REFILE PAPER CLAIM WITH MEDICARE EOB</b>	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	<b>Paid at Medicaid per diem rate; paid maximum allowable.</b>	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	<b>Paid at Medicaid per diem rate; paid maximum allowable.</b>	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
900	<b>Claim denied for lack of requested information.</b>	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	<b>Claim denied for lack of requested information.</b>	125	Submission-billing error(s)	N29	Missing documentation-orders-notes- summary- report- chart.	95	Requested additional information not received.
901	<b>No adjustment due.</b>	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement		<b>No Mapping Required</b>		104 - Processed according to plan provisions.
902	<b>Claim paid - EAC price adjusted.</b>	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	<b>Claim paid - EAC price adjusted.</b>	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	<b>Claim paid - EAC price adjusted.</b>	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	<b>Claim paid - EAC price adjusted.</b>	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	<b>Claim paid - MAC price adjusted.</b>	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	<b>Claim paid - MAC price adjusted.</b>	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	65	Claim-line has been paid.

903	Claim paid - MAC price adjusted.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N45	Payment based on authorized amount.	107	Processed according to contract-plan provisions.
903	Claim paid - MAC price adjusted.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.
904	Claim paid - AWP price adjusted.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N45	Payment based on authorized amount.	65	Claim-line has been paid.
904	Claim paid - AWP price adjusted.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.
907	Full recoupment per pharmacy of record review.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.
909	Please resubmit claim with both mileage and base fee coded to the same level of service, (ie: ALS or BLS).	150	Payer deems the information submitted does not support this level of service	M22	Missing-incomplete-invalid number of miles traveled.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
910	Rebill with form 5016 indicating patient liability amount.	125	Submission-billing error(s)	N34	Incorrect claim form-format for this service.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
910	Rebill with form 5016 indicating patient liability amount.	125	Submission-billing error(s)	N58	Missing-incomplete-invalid patient liability amount	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
911	Denied CMS termination.	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service.		No Mapping Required	104	Processed according to plan provisions.

912	Provider must enroll with the Division of Medical Assistance. Visit our website for an enrollment packet or contact Provider Services at 1 800 688 6696 Option 3.	133	The disposition of this claim-service is pending further review.	MA07	Alert- The claim information has also been forwarded to Medicaid for review	16	Claim-encounter has been forwarded to entity.
916	Resubmit claim with the post-evaluation report and applicable invoices.	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes- summary- report- chart.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
916	Resubmit claim with the post-evaluation report and applicable invoices.	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes- summary- report- chart.	294	Supporting documentation.
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	Entity's 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	Entity's 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	Entity's 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	Entity's 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	Entity's 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
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

927	Code is to cover 24 hours, therefore only one unit allowed per day.	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	259	Frequency of service.
927	Code is to cover 24 hours, therefore only one unit allowed per day.	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame.	612	Per Day Limit Amount
932	CLIA cert info could not be verified. Verify CLIA number on summary page. Contact your state CLIA authority-NC providers contact NC DFS CLIA PO BOX 29530 Raleigh NC 27626.	125	Submission-billing error(s)	MA120	Missing-incomplete-invalid CLIA certification number.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
932	CLIA cert info could not be verified. Verify CLIA number on summary page. Contact your state CLIA authority-NC providers contact NC DFS CLIA PO BOX 29530 Raleigh NC 27626.	125	Submission-billing error(s)	MA120	Missing-incomplete-invalid CLIA certification number.	142	Entity's license-certification number.
932	CLIA cert info could not be verified. Verify CLIA number on summary page. Contact your state CLIA authority-NC providers contact NC DFS CLIA PO BOX 29530 Raleigh NC 27626.	125	Submission-billing error(s)	MA120	Missing-incomplete-invalid CLIA certification number.	630	Referring CLIA Number
936	CLIA cert not valid for DOS-level. If you have only 1 CLIA #, contact agency that issued cert. If multi CLIA#, send copy of cert-claim & inquiry form to HP Provider Services.	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service.	MA120	Missing-incomplete-invalid CLIA certification number.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

936	CLIA cert not valid for DOS-level. If you have only 1 CLIA #, contact agency that issued cert. If multi CLIA#, send copy of cert-claim & inquiry form to HP Provider Services.	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service.	MA120	Missing-incomplete-invalid CLIA certification number.	142	Entitys license-certification number.
936	CLIA cert not valid for DOS-level. If you have only 1 CLIA #, contact agency that issued cert. If multi CLIA#, send copy of cert-claim & inquiry form to HP Provider Services.	B7	This provider was not certified-eligible to be paid for this procedure-service on this date of service.	MA120	Missing-incomplete-invalid CLIA certification number.	630	Referring CLIA Number
940	The recipient first initial and last name required.	125	Submission-billing error(s)	MA36	Missing-incomplete-invalid patient name	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
940	The recipient first initial and last name required.	125	Submission-billing error(s)	MA36	Missing-incomplete-invalid patient name	125	Entitys name.
942	Prescriber name or DEA number is required .	125	Submission-billing error(s)	N31	Missing-incomplete-invalid prescribing provider identifier.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
942	Prescriber name or DEA number is required .	125	Submission-billing error(s)	N31	Missing-incomplete-invalid prescribing provider identifier.	150	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.

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	<b>Alert-</b> 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.		<b>No Mapping Required</b>	107	Processed according to contract-plan provisions.
953	Individual has restricted coverage - Medicaid only pays the part B premium.	109	Claim not covered by this payer-contractor. You must send the claim to the correct payer-contractor.		<b>No Mapping Required</b>	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	<b>Alert-</b> 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
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
960	Please specify the name of the medication given in this injection.	125	Submission-billing error(s)	M123	Missing-incomplete-invalid name, strength, or dosage of the drug furnished.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
960	Please specify the name of the medication given in this injection.	125	Submission-billing error(s)	M123	Missing-incomplete-invalid name, strength, or dosage of the drug furnished.	409	Medication logs-records (including medication therapy).
962	Writing prescriptions for medication is included in your fee for services.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	454	Procedure code for services rendered.
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	<b>A therapeutic abortion procedure is not billed on this claim. Please remove the therapeutic diagnosis code from your claim and resubmit.</b>	11	The diagnosis is inconsistent with the procedure.	M76	Missing-incomplete-invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered
973	<b>Non-emergent ambulance:one-way transportation and round trip transportation are not allowed on the same day.</b>	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service 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	<b>Code invalid for this DOS.</b>	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	<b>Code invalid for this DOS.</b>	125	Submission-billing error(s)	MA31	Missing-incomplete-invalid beginning and ending dates of the period billed.	187	Date(s) of service.
975	<b>Documentation does not support the necessity for air ambulance. Change miles to reflect ground transport. Do not change your codes. Resubmit as an adjustment.</b>	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	<b>Documentation does not support the necessity for air ambulance. Change miles to reflect ground transport. Do not change your codes. Resubmit as an adjustment.</b>	16	Claim-service lacks information which is needed for adjudication	N206	The supporting documentation does not match the claim	428	Reason for transport by ambulance

976	Air ambulance services cut back to ground reimbursement.	150	Payer deems the information submitted does not support this level of service	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	454	Procedure code for services rendered.
977	Service denied. No transport of patient.	115	Procedure postponed-canceled-or delayed.		No Mapping Required	104	Processed according to plan provisions.
978	ALS not documented, please refile as an adjustment with further documentation, or refile as a BLS service.	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes- summary- report- chart.	123	Additional information requested from entity.
978	ALS not documented, please refile as an adjustment with further documentation, or refile as a BLS service.	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes- summary- report- chart.	294	Supporting documentation.
979	ALS not documented, code changed to reflect BLS service.	150	Payment adjusted because the payer deems the information submitted does not support this level of service	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	454	Procedure code for services rendered
980	Miles cut back to the nearest appropriate facility.	117	Transportation is only covered to the closest facility that can provide the necessary care	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	267	Number of miles patient was transported.
980	Miles cut back to the nearest appropriate facility.	117	Transportation is only covered to the closest facility that can provide the necessary care	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	430	Nearest appropriate facility
985	Exceeds monthly legislative limit for prescriptions.	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same-similar procedure within set time frame	259	Frequency of service.
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
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.
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).
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.
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.

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.
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.

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.
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.
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.
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.
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.
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.
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.
1073	A negative dollar amount was submitted on your claim. Negative values are not permitted. Please correct and resubmit as a new claim.	125	Submission-billing error(s)	M49	Missing-incomplete-invalid value code(s) or amount(s).	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1078	Optical claim form 372-017 is no longer accepted. Please resubmit optical supply charges on the CMS-1500 claim.	125	Submission-billing error(s)	N34	Incorrect claim form-format for this service.	276	UB04-HCFA-1450-1500 claim form
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.

<b>1079</b>	<b>Detail units of RC229 must equal the number of days calculated from the “from &amp; to” dates in form locator 6 on approved UB. Correct your claim dates of service and resubmit.</b>	<b>151</b>	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	<b>M52</b>	Missing-incomplete-invalid from date(s) of service.	<b>476</b>	Missing or invalid units of service.
<b>1079</b>	<b>Detail units of RC229 must equal the number of days calculated from the “from &amp; to” dates in form locator 6 on approved UB. Correct your claim dates of service and resubmit.</b>	<b>151</b>	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	<b>M59</b>	Missing-incomplete-invalid to date(s) of service.	<b>476</b>	Missing or invalid units of service.
<b>1080</b>	<b>Exceeds one per day limitation.</b>	<b>119</b>	Benefit maximum for this time period or occurrence has been reached.	<b>M86</b>	Service denied because payment already made for same-similar procedure within set time frame.	<b>259</b>	Frequency of service.
<b>1087</b>	<b>Insufficient documentation in records received to support therapeutic abortion to save life of mother. Resubmit with additional medical records as new day claim.</b>	<b>150</b>	Payer deems the information submitted does not support this level of service	<b>N29</b>	Missing documentation-orders-notes-summary-report-chart.	<b>21</b>	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
<b>1087</b>	<b>Insufficient documentation in records received to support therapeutic abortion to save life of mother. Resubmit with additional medical records as new day claim.</b>	<b>150</b>	Payer deems the information submitted does not support this level of service	<b>N206</b>	The supporting documentation does not match the claim	<b>21</b>	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
<b>1087</b>	<b>Insufficient documentation in records received to support therapeutic abortion to save life of mother. Resubmit with additional medical records as new day claim.</b>	<b>150</b>	Payer deems the information submitted does not support this level of service	<b>N29</b>	Missing documentation-orders-notes-summary-report-chart.	<b>294</b>	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
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	<b>Alert-</b> 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	<b>Alert-</b> 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.
1107	POS - Pharmacy initiated reversal.	B5	Coverage-program guidelines were not met or were exceeded.		<b>No Mapping Required</b>	107	Processed according to contract-plan provisions.

1112	<b>Related services not allowed on same date of service</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>258</b>	Days-units for procedure-revenue code.
1149	<b>Claim denied, PA is required for rental of apnea monitor.</b>	<b>197</b>	Precertification-authorization-notification absent.	<b>N54</b>	Claim information is inconsistent with pre-certified-authorized services.	<b>48</b>	Referral-authorization.
1149	<b>Claim denied, PA is required for rental of apnea monitor.</b>	<b>197</b>	Precertification-authorization-notification absent.	<b>N54</b>	Claim information is inconsistent with pre-certified-authorized services.	<b>84</b>	Service not authorized.
1154	<b>Claim denied pending rate information from DMA. Call HP, Provider Services at 1-800-688-6696.</b>	<b>133</b>	The disposition of this claim-service is pending further review.		<b>No Mapping Required</b>	<b>3</b>	Claim has been adjudicated and is awaiting payment cycle.
1156	<b>A valid hysterectomy statement is on file. Submit adjustment with records to support medical necessity, include: H&amp;P/physical/operative records/path report &amp; discharge summary</b>	<b>16</b>	Claim-service lacks information which is needed for adjudication	<b>N29</b>	Missing-incomplete-invalid documentation-orders-notes-summary-report-chart	<b>21</b>	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1156	<b>A valid hysterectomy statement is on file. Submit adjustment with records to support medical necessity, include: H&amp;P/physical/operative records/path report &amp; discharge summary</b>	<b>16</b>	Claim-service lacks information which is needed for adjudication	<b>N29</b>	Missing-incomplete-invalid documentation-orders-notes-summary-report-chart	<b>287</b>	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.
1160	Dates of service are later than the last certified date of service. Noncertified days are not reimbursable. For assistance contact FMH at 800-770-3084 ext.3236.	27	Expenses incurred after coverage terminated.	M59	Missing-incomplete-invalid-to-date(s) of service.	187	Date(s) of service.
1170	This procedure or procedure-modifier combination is edited for units, therefore billing a span of days is not allowed. Please bill each date of service on a separate detail	125	Submission-billing error(s)	M53	Missing-incomplete-invalid days or units of service.	258	Days-units for procedure-revenue code.
1170	This procedure or procedure-modifier combination is edited for units, therefore billing a span of days is not allowed. Please bill each date of service on a separate detail	125	Submission-billing error(s)	M53	Missing-incomplete-invalid days or units of service.	453	Procedure code modifier(s) for service(s) rendered.
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)
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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> Please refer to your provider manual for additional program and provider information	255	Diagnosis code.
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.
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	<b>Alert-</b> 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	<b>Alert-</b> Consult plan benefit documents for information about restrictions for this service	476	Missing or invalid units 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		<b>No Mapping Required</b>	585	Denied Charge or Non-covered Charge.
1204	CLIA number is either incorrect-missing from the claim or you have billed a test-DOS outside your CLIA certification.	125	Submission-billing error(s)	MA120	Missing-incomplete-invalid CLIA certification number.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1204	CLIA number is either incorrect-missing from the claim or you have billed a test-DOS outside your CLIA certification.	125	Submission-billing error(s)	MA120	Missing-incomplete-invalid CLIA certification number.	142	Entitys license-certification number.
1204	CLIA number is either incorrect-missing from the claim or you have billed a test-DOS outside your CLIA certification.	125	Submission-billing error(s)	MA120	Missing-incomplete-invalid CLIA certification number.	630	Referring CLIA Number
1206	V diagnosis is not allowed as a principle diagnosis.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing-incomplete-invalid diagnosis or condition.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

1206	V diagnosis is not allowed as a principle diagnosis.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing-incomplete-invalid diagnosis or condition.	255	Diagnosis Code
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.
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).

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.
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.
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.
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.
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.
1319	Procedure code without units denied, correct claim and resubmit as a new claim.	151	Payment adjusted because the payer deems the information submitted does not support this many-frequency of services	M53	Missing-incomplete-invalid days or units of service.	476	Missing or invalid units of service

1335	Encounter. Provider number is missing. Enter provider number and resubmit.	125	Submission-billing error(s)	N77	Missing-incomplete-invalid designated provider number.	132	Entity's Medicaid provider id. Note- This code requires use of an Entity 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.
1340	Client behavior intervention services not allowed without a mental health or substance abuse diagnosis.	11	The diagnosis is inconsistent with the procedure.	M76	Missing-incomplete-invalid diagnosis or condition.	255	Diagnosis code.
1344	Service not allowed without a mental disorder diagnosis.	11	The diagnosis is inconsistent with the procedure.	M76	Missing-incomplete-invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered
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	<b>Excision, each additional lesion must bill with primary proc</b>	107	The related or qualifying claim-service was not identified on this claim. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	<b>N19</b>	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered.
1346	<b>Excision, each additional lesion must bill with primary proc</b>	107	The related or qualifying claim-service was not identified on this claim. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	<b>N161</b>	This drug-service-supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered.
1350	<b>Provider signature not on file. Sign claim and resubmit or complete 'certification for signature on file' form located</b>	16	Claim-service lacks information which is needed for adjudication	<b>MA81</b>	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.
							Entities original signature. Note

1351	Provider signature not on file. Sign claim and resubmit or complete 'certification for signature on file' form located on DMA's website under provider links, provider forms	16	Claim-service lacks information which is needed for adjudication	MA81	Missing-incomplete-invalid provider-supplier signature	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1351	Provider signature not on file. Sign claim and resubmit or complete 'certification for signature on file' form located on DMA's website under provider links, provider forms	16	Claim-service lacks information which is needed for adjudication	MA81	Missing-incomplete-invalid provider-supplier signature	117	Claim requires signature-on-file indicator.
1351	Provider signature not on file. Sign claim and resubmit or complete 'certification for signature on file' form located on DMA's website under provider links, provider forms	16	Claim-service lacks information which is needed for adjudication	MA81	Missing-incomplete-invalid provider-supplier signature	466	Entities original signature. Note This code requires use of an Entity Code. This change effective 11-1-2011- Entitys Original Signature. Note- This code requires use of an Entity Code.
1355	PA number or amount billed does not match the CMNPA form. Review, correct and resubmit as a new claim.	197	Precertification-authorization-notification absent.	M62	Missing-incomplete-invalid treatment authorization code.	48	Referral-authorization.
1355	PA number or amount billed does not match the CMNPA form. Review, correct and resubmit as a new claim.	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	48	Referral-authorization.
1355	PA number or amount billed does not match the CMNPA form. Review, correct and resubmit as a new claim.	197	Precertification-authorization-notification absent.	M62	Missing-incomplete-invalid treatment authorization code.	178	Submitted charges.

1355	PA number or amount billed does not match the CMNPA form. Review, correct and resubmit as a new claim.	197	Precertification-authorization-notification absent.	N54	Claim information is inconsistent with pre-certified-authorized services.	178	Submitted charges.
1358	Medicaid considers this code to be an integral component to the total procedure. Separate reimbursement is not made.	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session-date as a previously processed service for the patient.	54	Duplicate of a previously processed claim-line.
1380	Refile claim on paper with itemized breakdown of charges.	16	Claim-service lacks information which is needed for adjudication	N225	Incomplete-invalid documentation-orders- notes-summary- report- chart.	277	Paper claim.
1380	Refile claim on paper with itemized breakdown of charges.	16	Claim-service lacks information which is needed for adjudication	N225	Incomplete-invalid documentation-orders- notes-summary- report- chart.	279	Itemized claim.
1381	Refile claim with itemized breakdown of charges.	A1	Claim-Service denied	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	279	Itemized claim.
1381	Refile claim with itemized breakdown of charges.	A1	Claim-Service denied	N26	Missing-incomplete-invalid itemized bill	279	Itemized claim.
1381	Refile claim with itemized breakdown of charges.	A1	Claim-Service denied	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	481	Claim-submission format is invalid.
1381	Refile claim with itemized breakdown of charges.	A1	Claim-Service denied	N26	Missing-incomplete-invalid itemized bill	481	Claim-submission format is invalid.

1382	Itemized bill does not support charges billed. Please review charges, correct claim, and resubmit for processing.	125	Submission-billing error(s)	M79	Missing-incomplete-invalid charge.	178	Submitted charges.
1382	Itemized bill does not support charges billed. Please review charges, correct claim, and resubmit for processing.	125	Submission-billing error(s)	N152	Missing-incomplete-invalid replacement claim information.	178	Submitted charges.
1382	Itemized bill does not support charges billed. Please review charges, correct claim, and resubmit for processing.	125	Submission-billing error(s)	M79	Missing-incomplete-invalid charge.	279	Itemized claim.
1382	Itemized bill does not support charges billed. Please review charges, correct claim, and resubmit for processing.	125	Submission-billing error(s)	N152	Missing-incomplete-invalid replacement claim information.	279	Itemized claim.
1385	DMA-PCG recovery project, at DMAs request on claims where other insurance was available to pay medical expenses. For questions, call Sue St. John, PCG, 1-800-372-0878.	133	The disposition of this claim-service is pending further review.		No Mapping Required	3	Claim has been adjudicated and is awaiting payment cycle.
1390	Medicare payment information for this detail is not listed on attached medicare voucher.	148	Information from another provider was not provided or was insufficient-incomplete	N4	Missing-incomplete-invalid prior insurance carrier EOB.	286	Other payers Explanation of Benefits-payment information.
1393	PREVIOUS STATE PAYOUT. RESUBMIT CLAIM WITH RA TO DMA, CLAIMS ANALYSIS UNIT, SEE BILLING GUIDEINES	A1	Claim-Service denied	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	104	Processed according to plan provisions (Plan refers to provisions that exist between the Health Plan and the Consumer or Patient)
1395	Please correct your claim by using a more specific hysterectomy procedure code.	125	Submission-billing error(s)	N56	Procedure code billed is not correct-valid for the service billed or the date of service billed.	454	Procedure code for services rendered.

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.
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.
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.
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.
1413	DMA-PCG repayment of recoupment. Claim originally recouped with EOB 1385. For questions, call PCG, 1-800-372-0878.	198	Precertification-authorization exceeded	N45	Payment based on authorized amount.	64	Re-pricing information.
1414	Provider initiated repayment of claim originally recouped with EOB 1385.	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N45	Payment based on authorized amount.	64	Re-pricing information.

1416	Exceeds 20 unit per year limitation.	119	Benefit maximum for this time period or occurrence has been reached.	N357	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	259	Frequency of service.
1416	Exceeds 20 unit per year limitation.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum	259	Frequency of service.
1424	Reflects overpayments for ach enhanced care PCS billed at higher level than authorized.	198	Precertification-authorization exceeded	N54	Claim information is inconsistent with pre-certified-authorized services.	64	Re-pricing information.
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.
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.
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.

1461	<b>Performance of the test physician supervision, report and interpretation included in the cardiac stress test.</b>	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 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.
1464	<b>Amino acids, qualitative not allowed to bill with multiple.</b>	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service 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	<b>Chromatography, quantitative, column not allowed to bill with multiple.</b>	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service 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	<b>Immunoassay for analyte other than antibody agent antigen, multiple step method not allowed to bill with single</b>	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service 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	<b>Immunoassay for analyte other than infectious agent for single step method not allowed with multiple step method.</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>258</b>	Days-units for procedure-revenue code.
1468	<b>Chromatography, quantitative, column, multiple analytes not allowed same DOS as single analyte.</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>258</b>	Days-units for procedure-revenue code.
1469	<b>Infectious agent analysis not allowed with HIV resistance testing.</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>258</b>	Days-units for procedure-revenue code.

1470	<b>Molecular diagnostics not allowed to bill with multiplex.</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>258</b>	Days-units for procedure-revenue code.
1481	<b>Cardiac stress test includes performance of the test, physician supervision, interpretation and report.</b>	<b>97</b>	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient.	<b>454</b>	Procedure code for services rendered.
1486	<b>Impotence drugs not covered for males under age 25, The physician (or designee) must obtain prior approval.</b>	<b>197</b>	Precertification-authorization-notification absent.	<b>N54</b>	Claim information is inconsistent with pre-certified-authorized services.	<b>475</b>	Procedure code not valid for patient age.
1502	<b>Components denied. Rebill using 81000 as the complete procedure, versus multiple components of urinalysis.</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>454</b>	Procedure code for services rendered.
1506	<b>Procedure denied. bronchoplasty procedure only allowed when billed in addition to primary surgery procedure. Review claim, correct and resubmit as a new claim.</b>	<b>107</b>	The related or qualifying claim-service was not identified on this claim. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	<b>N161</b>	This drug-service-supply is covered only when the associated service is covered.	<b>465</b>	Principal Procedure Code for Service(s) Rendered.

1513	<b>Professional treatment services in crisis facilities limited to 15 consecutive days. Correct claim and rebill.</b>	119	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.
1521	<b>Professional component of this procedure code has already been reimbursed for this date. Rebill for technical component only.</b>	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 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.
1536	<b>Residential evaluation service recouped. Service not allowed during inpatient or nursing home stay.</b>	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other 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	<b>Units were changed to allow a maximum of 14 units per day.</b>	119	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	<b>Units were changed to allow a maximum of 14 units per day.</b>	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	<b>Units were changed to allow a maximum of 14 units per day.</b>	119	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	<b>Units were changed to allow a maximum of 14 units per day.</b>	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 prophylaxis and fluoride with correct combination procedure code (D1201 or D1205).	125	Submission-billing error(s)	MA66	Missing-incomplete-invalid principal procedure code or date.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

1544	Recipient has reached 21st birthday and has exceeded 8 unmanaged visits. PA from Value Options (888-510-1150) is required. Retrospective review is not allowed.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum	259	Frequency of service.
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.
1551	8 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.

1551	8 psychiatric outpatient visits allowed without prior approval.	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.
1553	REFER to 1998 CPT for HIV viral load codes and refile.	125	Submission-billing error(s)	MA66	Missing-incomplete-invalid principal procedure code or date.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1556	Other diagnosis code 6 must be further subdivided. (the code must have four or five digits)	146	Diagnosis was invalid for the date(s) of service reported.	M81	You are required to code to the highest level of specificity	255	Diagnosis code.
1557	Other diagnosis code 7 must be further subdivided. (the code must have four or five digits)	146	Diagnosis was invalid for the date(s) of service reported.	M81	You are required to code to the highest level of specificity	255	Diagnosis code.
1558	Other diagnosis code 8 must be further subdivided. (the code must have four or five digits)	146	Diagnosis was invalid for the date(s) of service reported.	M81	You are required to code to the highest level of specificity	255	Diagnosis code.
1559	Other diagnosis code 9 must be further subdivided. (the code must have four or five digits)	146	Diagnosis was invalid for the date(s) of service reported.	M81	You are required to code to the highest level of specificity	255	Diagnosis code.
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.

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.
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.

<b>1570</b>	<b>Recoup PCS when HRI-RI is paid.</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>259</b>	Frequency of service.
<b>1575</b>	<b>Inpatient services billed same day PDN, not allowed</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>259</b>	Frequency of service.
<b>1580</b>	<b>Recipient must be undergoing chronic hemodialysis (RC821).</b>	<b>107</b>	The related or qualifying claim-service was not identified on this claim. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	<b>N161</b>	This drug-service-supply is covered only when the associated service is covered.	<b>454</b>	Procedure code for services rendered.
<b>1583</b>	<b>Hospice and PDN services not allowed same day. PDN claim paid for this date of service</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>187</b>	Date(s) 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.
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.
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.

<b>1615</b>	<b>Claim denied. More than one diagnosis code within range 76400 - 76519</b>	<b>167</b>	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 Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	<b>M64</b>	Missing-incomplete-invalid other diagnosis.	<b>488</b>	Diagnosis code(s) for the services rendered.
<b>1621</b>	<b>Invalid DRG grouping due to incorrect/insufficient coding. Include weight of newborn on claim and resubmit.</b>	<b>A1</b>	Claim-Service denied	<b>208</b>	Missing-incomplete-invalid DRG code.	<b>256</b>	DRG code(s).
<b>1621</b>	<b>Invalid DRG grouping due to incorrect/insufficient coding. Include weight of newborn on claim and resubmit.</b>	<b>A1</b>	Claim-Service denied	<b>207</b>	Missing-incomplete-invalid weight.	<b>273</b>	Weight.
<b>1621</b>	<b>Invalid DRG grouping due to incorrect/insufficient coding. Include weight of newborn on claim and resubmit.</b>	<b>A1</b>	Claim-Service denied	<b>208</b>	Missing-incomplete-invalid DRG code.	<b>273</b>	Weight.
<b>1628</b>	<b>Related lab test included in acute hepatitis panel.</b>	<b>97</b>	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient.	<b>454</b>	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.
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.
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
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.
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.
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
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
1668	Other diagnosis code 6 is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing-incomplete-invalid diagnosis or condition.	255	Diagnosis code.
1669	Other diagnosis code 7 is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing-incomplete-invalid diagnosis or condition.	255	Diagnosis code.
1670	Other diagnosis code 8 is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing-incomplete-invalid diagnosis or condition.	255	Diagnosis code.
1671	Other diagnosis code 9 is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing-incomplete-invalid diagnosis or condition.	255	Diagnosis code.
1674	Diagnosis billed is not allowed as primary diagnosis	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.
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.
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	<b>Alert-</b> 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	<b>Alert-</b> Please refer to your provider manual for additional program and provider information	615	Policy Compliance Code.
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.
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
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
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.
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	<b>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</b>	125	Submission-billing error(s)	<b>M49</b>	Missing-incomplete-invalid value code(s) or amount(s).	<b>500</b>	Entitys Postal-Zip Code.
1719	<b>The hospice revenue code billed must be billed with a value code of 61 and corresponding CBSA code.</b>	125	Submission-billing error(s)	<b>M49</b>	Missing-incomplete-invalid value code(s) or amount(s).	<b>21</b>	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1719	<b>The hospice revenue code billed must be billed with a value code of 61 and corresponding CBSA code.</b>	125	Submission-billing error(s)	<b>M49</b>	Missing-incomplete-invalid value code(s) or amount(s).	<b>726</b>	NUBC Value Code Amount(s)
1720	<b>NDC validity cannot be confirmed</b>	125	Submission-billing error(s)	<b>M119</b>	Missing-incomplete-invalid-deactivated-withdrawn National Drug Code (NDC).	<b>218</b>	NDC number
1721	<b>Related MRI procedure not allowed on same date of service, same or different provider.</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>258</b>	Days-units for procedure-revenue code.
1725	<b>Related Mammography screenings not allowed on the same date of service</b>	<b>119</b>	Benefit maximum for this time period or occurrence has been reached	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient.	<b>259</b>	Frequency of service.
1725	<b>Related Mammography screenings not allowed on the same date of service</b>	<b>119</b>	Benefit maximum for this time period or occurrence has been reached	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>259</b>	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
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)
1746	The core (billing) and service level (attending) provider type and specialty combination are not valid for the service billed	A1	Claim-Service denied	N95	This provider type - provider specialty may not bill this service	454	Procedure code for services rendered
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	18	Entity received claim-encounter, but returned invalid status
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	<b>Related fetal biophysical profile procedures not allowed on the same date of service.</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>258</b>	Days-units for procedure-revenue code.
1751	<b>Related prostate specific antigen (PSA) procedures not allowed on the same date of service</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>258</b>	Days-units for procedure-revenue code.
1753	<b>Vitamin, unspecified not on same date of service as vitamins A or K.</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>258</b>	Days-units for procedure-revenue code.

1755	<b>Drug/Implant must be billed with the appropriate administration code</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M51</b>	Missing-incomplete-invalid procedure code(s).	<b>465</b>	Principal Procedure Code for Service(s) Rendered
1758	<b>This procedure included in a more comprehensive audiometry procedure billed on same date of service.</b>	<b>97</b>	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient.	<b>454</b>	Procedure code for services rendered.
1759	<b>Procedure recouped to allow reimbursement of more comprehensive procedure.</b>	<b>97</b>	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient.	<b>454</b>	Procedure code for services rendered.
1770	<b>Invalid procedure-modifier-diagnosis code combination for Health Check or Family Planning services. Correct and resubmit as a new claim.</b>	<b>4</b>	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		<b>No Mapping Required</b>	<b>255</b>	Diagnosis code.
1772	<b>Maximum allowable for Health Department Immunization Administration has already been paid.</b>	<b>B13</b>	Previously paid. Payment for this claim-service may have been provided in a previous payment		<b>No Mapping Required</b>	<b>483</b>	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
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.
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.
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 reached	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 reached	M86	Service denied because payment already made for same-similar procedure within set time frame.	612	Per Day Limit Amount
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.
1799	Recipient is not eligible for medicaid claims payment due to current living arrangement.	32	Our records indicate that this dependent is not an eligible dependent as defined.	N424	Patient does not reside in the geographic area required for this type of payment.	109	Entity not eligible. Note- This code requires use of an Entity Code.

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.
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	<b>Alert-</b> Do not resubmit this claim-service	585	Denied Charge or Non-covered Charge
1810	Your claim is denied. Submit all required PCS documentation with your claim to DMA Program Integrity Home Care	A1	Claim-Service denied	N29	Missing documentation-orders-notes-summary-report-chart.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1810	Your claim is denied. Submit all required PCS documentation with your claim to DMA Program Integrity Home Care	A1	Claim-Service denied	N225	Incomplete-invalid documentation-orders-notes-summary-report-chart.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
1810	Your claim is denied. Submit all required PCS documentation with your claim to DMA Program Integrity Home Care	A1	Claim-Service denied	N29	Missing documentation-orders-notes-summary-report-chart.	294	Supporting documentation

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

1824	<b>The comprehensive metabolic panel includes the basic metabolic &amp; hepatic function panels. Reimbursement is based on CPT 80053.</b>	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient.	<b>454</b>	Procedure code for services rendered.
1842	<b>Bill type submitted requires appropriate external cause diagnosis. External cause diagnosis is missing or invalid. Correct claim and resubmit</b>	125	Submission-billing error(s)	<b>M76</b>	Missing-incomplete-invalid diagnosis or condition.	<b>228</b>	Type of bill for UB claim
1848	<b>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</b>	125	Submission-billing error(s)	<b>M76</b>	Missing-incomplete-invalid diagnosis or condition.	<b>228</b>	Type of bill for UB claim
1849	<b>NEVER EVENT, PAID \$0.00</b>	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.	<b>N180</b>	This item or service does not meet the criteria for the category under which it was billed.	<b>287</b>	Medical necessity for service.
1850	<b>CABHA provider does not meet enrollment criteria</b>	A1	Claim-Service denied	<b>N36</b>	Claim must meet primary payers processing requirements before we can consider payment.	<b>275</b>	Claim
1850	<b>CABHA provider does not meet enrollment criteria</b>	A1	Claim-Service denied	<b>N59</b>	Please refer to your provider manual for additional program and provider information.	<b>275</b>	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
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.	259	Frequency of service.
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.	259	Frequency of service.
1864	Only 3 units allowed per date of service.	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-		

<b>1921</b>	<b>Personal care services not allowed on same day as Adult Care Home personal care service</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>258</b>	Days-units for procedure-revenue code.
<b>1924</b>	<b>Personal care services not allowed same day as Hospice</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>258</b>	Days-units for procedure-revenue code.
<b>1925</b>	<b>Related services not allowed on same date of service</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>258</b>	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.
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.
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.
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.
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
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
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
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?
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
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
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.
2046	Adjustment request denied. Adjustment-replacement claims for specialized therapy services will be adjusted systematically	A1	Claim-Service denied	N185	<b>Alert-</b> Do not resubmit this claim-service.	45	Awaiting benefit determination.
							Awaiting benefit determination.

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
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.
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.
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
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.
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.
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.

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	Entity's address.
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.
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.

2167	<b>Multiple clinic visits not allowed for crossover processing.</b>	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service 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	<b>Medical care for crossover processing not allowed to bill the same date as Office visit.</b>	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service 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	<b>Office visit not allowed to bill the same date as medical care for crossover processing.</b>	B15	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service 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.
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).
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.
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	9	The diagnosis is inconsistent with	M76	Missing-incomplete-invalid	254	Primary diagnosis code.
					Payment based on professional		

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. <b>This change to be effective 7-1-2010- The procedure code is inconsistent with the modifier used or a required modifier is missing.</b>	N13	Payment based on professional technical component modifier(s).	453	Procedure Code Modifier(s) for Service(s) Rendered
2210	Detail recouped. Resubmit detail with U2 modifier if recipient was inpatient, in	4	The procedure code is inconsistent with the modifier used or a required modifier is	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
					Payment based on professional		

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.
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.
			Healthcare Policy Identification				

2245	<b>Transfer of penalty from system adjustment to active provider with same Tax ID. Original provider is no longer active.</b>	<b>B7</b>	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		<b>No Mapping Required</b>	<b>1</b>	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.
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	<b>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</b>	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.
2279	<b>This recipient is not an SA eligible recipient; therefore this service is being denied.</b>	177	Patient has not met the required eligibility requirements.		<b>No Mapping Required</b>	91	Entity not eligible-not approved for dates of service.
2280	<b>Claim Denied. SCU-A Services not allowed same day as hospice.</b>	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	<b>Claim Denied. SCU-A Services not allowed same day as hospice.</b>	169	Alternate benefit has been provided.	N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.
2281	<b>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</b>	177	Patient has not met the required eligibility requirements.		<b>No Mapping Required</b>	84	Service not authorized.
2324	<b>Candida, gardnerella and trichomonas are all included in the same fee.</b>	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 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.

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	<b>Alert-</b> 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	<b>Alert-</b> 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
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.
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-invalid 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
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
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.

<b>2720</b>	<b>Semen analysis must be billed within 90 days of sterilization for MAFD recipients</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M67</b>	Missing-incomplete-invalid other procedure code(s).	<b>454</b>	Procedure code for services rendered.
<b>2899</b>	<b>RC452 not allowed without corresponding RC451.</b>	<b>107</b>	The related or qualifying claim-service was not identified on this claim. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	<b>N19</b>	Procedure code incidental to primary procedure.	<b>258</b>	Days-units for procedure-revenue code.
<b>2899</b>	<b>RC452 not allowed without corresponding RC451.</b>	<b>107</b>	The related or qualifying claim-service was not identified on this claim. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	<b>N161</b>	This drug-service-supply is covered only when the associated service is covered.	<b>258</b>	Days-units for procedure-revenue code.
<b>2751</b>	<b>DME service recouped. Not allowed same day as service rendered for CAP provider.</b>	<b>A1</b>	Claim-Service denied	<b>M80</b>	Not covered when performed during the same session/date as a previously processed service for the patient.	<b>453</b>	Procedure code modifier(s) for service(s) rendered.
<b>2751</b>	<b>DME service recouped. Not allowed same day as service rendered for CAP provider.</b>	<b>A1</b>	Claim-Service denied	<b>M86</b>	Service denied because payment already made for same/similar procedure within set timeframe.	<b>453</b>	Procedure code modifier(s) for service(s) rendered.
<b>2751</b>	<b>DME service recouped. Not allowed same day as service rendered for CAP provider.</b>	<b>A1</b>	Claim-Service denied	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>453</b>	Procedure code modifier(s) for service(s) rendered.
<b>2901</b>	<b>Denied due to inactive EFT status</b>	<b>A1</b>	Claim-Service denied	<b>N24</b>	Missing-incomplete-invalid Electronic Funds Transfer (EFT) banking information.	<b>585</b>	Denied Charge or Non-covered Charge

2905	POS - version-release number invalid .	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2930	POS - claim or reversal greater than 365 days old. Refile claim (paper) with proper documentation for time limit override.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
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.

2982	DAW 1 not allowed on this drug	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N59	Alert- Please refer to your provider manual for additional program and provider information	1	For more detailed information, see remittance advice.
2982	DAW 1 not allowed on this drug	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N59	Alert- Please refer to your provider manual for additional program and provider information	217	Drug name, strength and dosage form.
2983	DAW 5 not allowed on this drug	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N59	Alert- Please refer to your provider manual for additional program and provider information	1	For more detailed information, see remittance advice.
2983	DAW 5 not allowed on this drug	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N59	Alert- Please refer to your provider manual for additional program and provider information	217	Drug name, strength and dosage form.
2984	DAW 7 not allowed on this drug	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N59	Alert- Please refer to your provider manual for additional program and provider information	1	For more detailed information, see remittance advice.
2984	DAW 7 not allowed on this drug	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N59	Alert- Please refer to your provider manual for additional program and provider information	217	Drug name, strength and dosage form.
2986	Detail line recouped, per provider request.	45	Charge exceeds fee schedule- maximum allowable or contracted- legislated fee arrangement	MA91	This determination is the result of the appeal you filed	104	Processed according to plan provisions.
2990	CISA claims must be billed with a valid referring provider number.	52	The referring-prescribing-rendering provider is not eligible to refer-prescribe-order-perform the service billed.	N286	Missing-incomplete-invalid referring provider primary identifier.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

2990	CISA claims must be billed with a valid referring provider number.	52	The referring-prescribing-rendering provider is not eligible to refer-prescribe-order-perform the service billed.	N286	Missing-incomplete-invalid referring provider primary identifier.	132	Entitys Medicaid provider id. Note- This code requires use of an Entity Code.
2991	RESUBMIT AS AN ADJUSTMENT WITH THE MEDICARE VOUCHER OR SUBMIT A PROFESSIONAL 837 TRANSACTION WITH THE MEDICARE DATA ELEMENTS POPULATED.	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	116	Claim submitted to incorrect payer.
2991	RESUBMIT AS AN ADJUSTMENT WITH THE MEDICARE VOUCHER OR SUBMIT A PROFESSIONAL 837 TRANSACTION WITH THE MEDICARE DATA ELEMENTS POPULATED.	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	286	Other payer's Explanation of Benefits (EOB).
2992	RESUBMIT AS ADJUSTMENT WITH MEDICARE VOUCHER OR SUBMIT A PROFESSIONAL 837 TRANSACTION WITH MEDICARE DATA ELEMENTS POPULATED. TPL AMOUNTS SHOULD NOT INCLUDE MEDICARE PAYMENTS.	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	286	Other payer's Explanation of Benefits (EOB).
2992	RESUBMIT AS ADJUSTMENT WITH MEDICARE VOUCHER OR SUBMIT A PROFESSIONAL 837 TRANSACTION WITH MEDICARE DATA ELEMENTS POPULATED. TPL AMOUNTS SHOULD NOT INCLUDE MEDICARE PAYMENTS.	22	This care may be covered by another payer per coordination of benefits.	N82	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.	286	Other payer's Explanation of Benefits (EOB).

2992	RESUBMIT AS ADJUSTMENT WITH MEDICARE VOUCHER OR SUBMIT A PROFESSIONAL 837 TRANSACTION WITH MEDICARE DATA ELEMENTS POPULATED. TPL AMOUNTS SHOULD NOT INCLUDE MEDICARE PAYMENTS.	22	This care may be covered by another payer per coordination of benefits.	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	286	Other payer's Explanation of Benefits (EOB.
2992	RESUBMIT AS ADJUSTMENT WITH MEDICARE VOUCHER OR SUBMIT A PROFESSIONAL 837 TRANSACTION WITH MEDICARE DATA ELEMENTS POPULATED. TPL AMOUNTS SHOULD NOT INCLUDE MEDICARE PAYMENTS.	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	655	Total Medicare Paid Amount
2992	RESUBMIT AS ADJUSTMENT WITH MEDICARE VOUCHER OR SUBMIT A PROFESSIONAL 837 TRANSACTION WITH MEDICARE DATA ELEMENTS POPULATED. TPL AMOUNTS SHOULD NOT INCLUDE MEDICARE PAYMENTS.	22	This care may be covered by another payer per coordination of benefits.	N82	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.	655	Total Medicare Paid Amount

2992	<b>RESUBMIT AS ADJUSTMENT WITH MEDICARE VOUCHER OR SUBMIT A PROFESSIONAL 837 TRANSACTION WITH MEDICARE DATA ELEMENTS POPULATED. TPL AMOUNTS SHOULD NOT INCLUDE MEDICARE PAYMENTS.</b>	22	This care may be covered by another payer per coordination of benefits.	<b>N192</b>	Patient is a Medicaid-Qualified Medicare Beneficiary.	<b>655</b>	Total Medicare Paid Amount
2993	<b>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</b>	125	Submission-billing error(s)	<b>M51</b>	Missing-incomplete-invalid, procedure code(s) and-or dates.	<b>21</b>	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2993	<b>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</b>	125	Submission-billing error(s)	<b>N61</b>	Rebill services on separate claims.	<b>21</b>	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2993	<b>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</b>	125	Submission-billing error(s)	<b>N301</b>	Missing-incomplete-invalid procedure date(s).	<b>21</b>	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
2993	<b>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</b>	125	Submission-billing error(s)	<b>N61</b>	Rebill services on separate claims.	<b>72</b>	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.		<b>No Mapping Required</b>	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.

3044	<b>Components of renal function panel recouped to allow reimbursement of panel code.</b>	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 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	<b>Components of renal function panel included in reimbursement of panel code.</b>	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 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	<b>Component of hepatic function panel recouped to allow reimbursement of panel code.</b>	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 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	<b>Component of hepatic function panel included in reimbursement of panel code.</b>	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 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	<b>Adjustment denied. Unrelated-non-covered services cannot be combined.</b>	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.
3087	Molecular diagnosis add on must be billed with primary 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 primary procedure.	125	Submission-billing error(s)	M51	Missing-incomplete-invalid procedure code(s).	454	Procedure code for services rendered.
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	Entity's 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	Entity's 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	Entity's 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	Entity's 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	Entity's specialty code.
3092	Billing NPI and/or billing taxonomy is missing.	206	National Provider Identifier - missing	N255	Missing-incomplete-invalid billing provider taxonomy.	562	Entity's 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	Entity's 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	Entity's 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	Entity's 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	Entity's 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	Entity's 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	Entity's 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	Entity's 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	Entity's National Provider Identifier (NPI)
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.
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.
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
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.
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.	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	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 <a href="http://www.cms.hhs.gov-mcd">http---</a> <a href="http://www.cms.hhs.gov-mcd">www.cms.hhs.gov-mcd</a> , 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 <a href="http://www.cms.hhs.gov-mcd">http---www.cms.hhs.gov-mcd</a> , 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
3395	Code allowed once per gestational period	A1	Claim-Service denied	M86	Service denied because payment already made for same-similar procedure within set time frame.	259	Frequency of service.
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	<b>Incorrect number of units billed for this service. Please correct and resubmit with corrected units</b>	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
3505	<b>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</b>	119	Benefit maximum for this time period 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	<b>Epogen services are limited to 13 occurrences per this calendar month. An Adjustment Request including medical records is required for review of additional occurrences</b>	119	Benefit maximum for this time period 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	<b>Units billed for Epogen procedure have been cutback to the maximum allowable units</b>	119	Benefit maximum for this time period 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	<b>Units billed for Epogen procedure have been cutback to the maximum allowable units</b>	119	Benefit maximum for this time period 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	<b>Epogen procedures are specific to units billed. Correct claim if necessary to combine units under one appropriate procedure and file as an adjustment</b>	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	<b>Epogen procedures are specific to units billed. Correct claim if necessary to combine units under one appropriate procedure and file as an adjustment</b>	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.
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
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
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
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
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.
4014	Participant goods and services cutback to the maximum dollar amount allowed per State Fiscal Year (SFY)	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	483	Maximum coverage amount met or exceeded for benefit period.
4016	Cutback to the maximum of \$1500.00 allowed per SFY for CAP/Mobility.	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.
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-adjudication must reference the newly assigned payer claim control number for this previously adjusted claim. Correct the payer claim control number and resubmit.
4102	You are attempting to adjust a claim that is either not found on our file or is not found on our file as previously paid.	125	Submission-billing error(s)	N152	Missing-incomplete-invalid replacement claim information.	495	Requests for re-adjudication must reference the newly assigned payer claim control number for this previously adjusted claim. Correct the payer claim control number and resubmit.
4103	You are attempting to void a claim that is either not found on our file or is not found on our file as previously paid.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	1	For more detailed information, see remittance advice.
4103	You are attempting to void a claim that is either not found on our file or is not found on our file as previously paid.	125	Submission-billing error(s)	N152	Missing-incomplete-invalid replacement claim information.	1	For more detailed information, see remittance advice
4103	You are attempting to void a claim that is either not found on our file or is not found on our file as previously paid.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	495	Requests for re-adjudication must reference the newly assigned payer claim control number for this previously adjusted claim. Correct the payer claim control number and resubmit.

4103	You are attempting to void a claim that is either not found on our file or is not found on our file as previously paid.	125	Submission-billing error(s)	N152	Missing-incomplete-invalid replacement claim information.	495	Requests for re-adjudication must reference the newly assigned payer claim control number for this previously adjusted claim. Correct the payer claim control number and resubmit.
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
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
4406	Less severe dup, same prov, same pro code, same DOS.	18	Exact duplicate claim-service	M86	Service denied because payment already made for same-similar procedure within set time frame.	54	Duplicate of a previously processed claim-line.
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.

4445	<b>Service not allowed while recipient is enrolled in a high risk intervention- Residential hospital.</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M86</b>	Service denied because payment already made for same-similar procedure within set time frame.	<b>258</b>	Days-units for procedure-revenue code.
4446	<b>Service recouped. Recipient is enrolled in a high risk intervention- residential hospital on the same DOS.</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M86</b>	Service denied because payment already made for same-similar procedure within set time frame.	<b>258</b>	Days-units for procedure-revenue code.
4450	<b>Claim denied as exact duplicate of previously paid claim with the same Medicare ICN.</b>	<b>18</b>	Exact duplicate claim-service	<b>M86</b>	Service denied because payment already made for same-similar procedure within set time frame.	<b>54</b>	Duplicate of a previously processed claim-line.
4456	<b>Claim already paid to Carolina Alternative agency responsible for the recipients county residence.</b>	<b>18</b>	Exact duplicate claim-service	<b>M86</b>	Service denied because payment already made for same-similar procedure within set time frame.	<b>54</b>	Duplicate of a previously processed claim-line.
4465	<b>Personal care service are not allowed when recipient is receiving inpatient services.</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M2</b>	Not paid separately when the patient is an inpatient.	<b>258</b>	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 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.
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
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
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 allow 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 allow 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 allow 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	<b>Basic Metabolic Panel recouped to allow reimbursement of Comprehensive Panel code</b>	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient.	<b>453</b>	Procedure Code Modifier(s) for Service(s) Rendered
4618	<b>Basic Metabolic Panel recouped to allow reimbursement of Comprehensive Panel code</b>	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M86</b>	Service denied because payment already made for same-similar procedure within set time frame.	<b>453</b>	Procedure Code Modifier(s) for Service(s) Rendered
4618	<b>Basic Metabolic Panel recouped to allow reimbursement of Comprehensive Panel code</b>	97	The benefit for this service is included in the payment-allowance for another service-procedure that has already been adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date	<b>453</b>	Procedure Code Modifier(s) for Service(s) Rendered
4619	<b>Service denied. Basic Metabolic Panel includes procedure as a component of the panel</b>	A1	Claim-Service denied	<b>M15</b>	Separately billed services-tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	<b>453</b>	Procedure Code Modifier(s) for Service(s) Rendered
4619	<b>Service denied. Basic Metabolic Panel includes procedure as a component of the panel</b>	A1	Claim-Service denied	<b>M86</b>	Service denied because payment already made for same-similar procedure within set time frame.	<b>453</b>	Procedure Code Modifier(s) for Service(s) Rendered
4619	<b>Service denied. Basic Metabolic Panel includes procedure as a component of the panel</b>	A1	Claim-Service denied	<b>M126</b>	Missing-incomplete-invalid individual lab codes included in the test.	<b>453</b>	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
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
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.

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
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
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.
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.

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

5203	Service rep by this procedure code-mod combination is not covered.	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct-valid for the service billed or the date of service billed.	457	Non-Covered Day(s).
5312	Prior authorized dollars exceeded.	198	Precertification-authorization exceeded	N54	Claim information is inconsistent with pre-certified-authorized services.	48	Referral-authorization.
5313	Prior authorized frequency exceeded.	198	Precertification-authorization exceeded	N54	Claim information is inconsistent with pre-certified-authorized services.	48	Referral-authorization.
5334	UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-2 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days-units for procedure-revenue code.
5334	UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-2 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	258	Days-units for procedure-revenue code.
5334	UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-2 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.
5334	UNITS CUTBACK. EXCEEDS MAXIMUM UNITS ALLOWED-2 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	259	Frequency of service.
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.
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
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.
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.

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	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-		



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.	259	Frequency of service.
6004	Unit Cutback. Exceeds the allowable 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.
6004	Unit Cutback. Exceeds the allowable units per 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.
6004	Unit Cutback. Exceeds the allowable 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.
6004	Unit Cutback. Exceeds the allowable units per 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.
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.
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.
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

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

6071	Test for antepartum sex determination is non-covered.	96	Non-covered charge(s). Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N115	This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD).	454	Procedure code for services rendered.
6082	Encounter: Negative amount was submitted on your claim. Negative values are not permitted. Please correct and resubmit		No Mapping Required		No Mapping Required		No Mapping Required
6099	Encounter: Billed services have been approved.		No Mapping Required		No Mapping Required		No Mapping Required
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
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.
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	<b>Units of SVC are not consistent with services billed. If dates are not consecutive, list each DOS on a separate line. Correct and resubmit.</b>	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	<b>Diagnosis or service invalid for recipient age. Verify MID, diagnosis &amp; procedure code; enter and resubmit.</b>	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.
6175	<b>Dialysis facility; this revenue code must be billed with the appropriate 5 digit CPT code. Correct denied detail and resubmit.</b>	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	<b>Encounter: HCPCS code required with RC250. If HCPC code was billed, this drug is included in monthly dialysis.</b>		No Mapping Required		No Mapping Required		No Mapping Required
6192	<b>Encounter: Diag. Or SVC. invalid for recip. age. Verify mid, diag., &amp; proc. code and resubmit.</b>		No Mapping Required		No Mapping Required		No Mapping Required
6202	<b>DRG-admission hour and-or discharge hour is invalid. Correct and resubmit.</b>	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
6260	Recipient mid number missing. Enter mid and resubmit.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
6261	Patient deceased per state eligibility file. Verify DOS and recipient mid and resubmit.	30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.		No Mapping Required	91	Entity not eligible-not approved for dates of service.
6267	DOS is prior to date of birth. Verify DOS and recipient mid and resubmit.	14	The date of birth follows the date of service.	MA61	Missing-incomplete-invalid social security number or health insurance claim number.	91	Entity not eligible-not approved for dates of service.
6300	Plan number missing or invalid. Enter corrected managed care plan number on the claim and resubmit.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.

6300	Plan number missing or invalid. Enter corrected managed care plan number on the claim and resubmit.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	515	Managed Care review
6320	DRG-principal or other procedure code invalid or requires further subdivision. Verify principal-other procedure code(s). Correct and resubmit.	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.
6320	DRG-principal or other procedure code invalid or requires further subdivision. Verify principal-other procedure code(s). 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.
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.	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	N1	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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.		<b>No Mapping Required</b>		<b>No Mapping Required</b>		<b>No Mapping Required</b>
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.

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
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	<b>DRG - Admitting-Principal-or other diagnosis code is invalid for recipient sex. Correct and resubmit.</b>	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	<b>M64</b>	Missing-incomplete-invalid other diagnosis.	86	Diagnosis and patient gender mismatch.
6423	<b>DRG - Admitting-Principal-or other diagnosis code is invalid for recipient sex. Correct and resubmit.</b>	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	<b>M76</b>	Missing-incomplete-invalid diagnosis or conditions.	86	Diagnosis and patient gender mismatch.
6423	<b>DRG - Admitting-Principal-or other diagnosis code is invalid for recipient sex. Correct and resubmit.</b>	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	<b>MA65</b>	Missing-incomplete-invalid admitting diagnosis.	86	Diagnosis and patient gender mismatch.
6423	<b>DRG - Admitting-Principal-or other diagnosis code is invalid for recipient sex. Correct and resubmit.</b>	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	<b>MA66</b>	Missing-incomplete-invalid principal procedure code or date.	86	Diagnosis and patient gender mismatch.
6423	<b>DRG - Admitting-Principal-or other diagnosis code is invalid for recipient sex. Correct and resubmit.</b>	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	<b>M64</b>	Missing-incomplete-invalid other diagnosis.	256	DRG code(s.)
6423	<b>DRG - Admitting-Principal-or other diagnosis code is invalid for recipient sex. Correct and resubmit.</b>	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	<b>M76</b>	Missing-incomplete-invalid diagnosis or conditions.	256	DRG code(s.)
6423	<b>DRG - Admitting-Principal-or other diagnosis code is invalid for recipient sex. Correct and resubmit.</b>	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	<b>MA65</b>	Missing-incomplete-invalid admitting diagnosis.	256	DRG code(s.)

6423	<b>DRG - Admitting-Principal-or other diagnosis code is invalid for recipient sex. Correct and resubmit.</b>	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	<b>DRG-admitting-principal-or other diagnosis code is invalid for recipient age. Correct and resubmit.</b>	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	<b>DRG-admitting-principal-or other diagnosis code is invalid for recipient age. Correct and resubmit.</b>	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	<b>DRG-admitting-principal-or other diagnosis code is invalid for recipient age. Correct and resubmit.</b>	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	<b>DRG-admitting-principal-or other diagnosis code is invalid for recipient age. Correct and resubmit.</b>	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	<b>DRG-admitting-principal-or other diagnosis code is invalid for recipient age. Correct and resubmit.</b>	9	The diagnosis is inconsistent with the patients age.	M64	Missing-incomplete-invalid other diagnosis.	255	Diagnosis code.
6424	<b>DRG-admitting-principal-or other diagnosis code is invalid for recipient age. Correct and resubmit.</b>	9	The diagnosis is inconsistent with the patients age.	M76	Missing-incomplete-invalid diagnosis or conditions.	255	Diagnosis code.
6424	<b>DRG-admitting-principal-or other diagnosis code is invalid for recipient age. Correct and resubmit.</b>	9	The diagnosis is inconsistent with the patients age.	MA65	Missing-incomplete-invalid admitting diagnosis.	255	Diagnosis code.



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.
6900	Encounter data withhold has been applied		No Mapping Required		No Mapping Required		No Mapping Required
6901	Encounter data withhold has been released		No Mapping Required		No Mapping Required		No Mapping Required
6909	Retroactive monthly capitated payment is prorated to match recipient eligibility for the month		No Mapping Required		No Mapping Required	107	Processed according to contract-plan provisions.
6960	Encounter: fees have been previously recouped. Upon subsequent review, reimbursement is being returned through this transaction.		No Mapping Required		No Mapping Required		No Mapping Required
6961	Due to a system error, claim paid incorrectly and has been recouped. Service for this recipient are covered by Kaiser. Please contact the HMO's member service # at 1-800-800-0901	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.

6961	Due to a system error, claim paid incorrectly and has been recouped. Service for this recipient are covered by Kaiser. Please contact the HMO's member service # at 1-800-800-0901	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	684	Rejected. Syntax error noted for this claim-service-inquiry. See Functional or Implementation Acknowledgement for details.
6962	Please contact ATLANTIC member service at 1-800-643-8483	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.
6962	Please contact ATLANTIC member service at 1-800-643-8483	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	684	Rejected. Syntax error noted for this claim-service-inquiry. See Functional or Implementation Acknowledgement for details.
6963	PLEASE CONTACT MAXICARE AT 1-800-350-6294	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.
6963	PLEASE CONTACT MAXICARE AT 1-800-350-6294	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	684	Rejected. Syntax error noted for this claim-service-inquiry. See Functional or Implementation Acknowledgement for details.
6964	PLEASE CONTACT GENERATIONS AT 1-800-256-5563	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.
6964	PLEASE CONTACT GENERATIONS AT 1-800-256-5563	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	684	Rejected. Syntax error noted for this claim-service-inquiry. See Functional or Implementation Acknowledgement for details.
6965	PLEASE CONTACT WELLNESS AT 1-800-794-9355	24	Charges are covered under a capitation agreement-managed care plan		No Mapping Required	96	No agreement with entity.

6965	<b>PLEASE CONTACT WELLNESS AT 1-800-794-9355</b>	24	Charges are covered under a capitation agreement-managed care plan		<b>No Mapping Required</b>	684	Rejected. Syntax error noted for this claim-service-inquiry. See Functional or Implementation Acknowledgement for details.
6966	<b>Please contact Optimum at 1-800-347-1957.</b>	24	Charges are covered under a capitation agreement-managed care plan		<b>No Mapping Required</b>	96	No agreement with entity.
6966	<b>Please contact Optimum at 1-800-347-1957.</b>	24	Charges are covered under a capitation agreement-managed care plan		<b>No Mapping Required</b>	684	Rejected. Syntax error noted for this claim-service-inquiry. See Functional or Implementation Acknowledgement for details.
6967	<b>Please contact United Health Care at 1-877-289-4419.</b>	24	Charges are covered under a capitation agreement-managed care plan		<b>No Mapping Required</b>	96	No agreement with entity.
6967	<b>Please contact United Health Care at 1-877-289-4419.</b>	24	Charges are covered under a capitation agreement-managed care plan		<b>No Mapping Required</b>	684	Rejected. Syntax error noted for this claim-service-inquiry. See Functional or Implementation Acknowledgement for details.
6996	<b>Encounter: patient not covered under plan during date(s) of service.</b>		<b>No Mapping Required</b>		<b>No Mapping Required</b>		<b>No Mapping Required</b>
6997	<b>Encounter: service(s) submitted not covered under plan schedule of Medicaid benefits.</b>		<b>No Mapping Required</b>		<b>No Mapping Required</b>		<b>No Mapping Required</b>

6998	Encounter processed. Service would have suspended for medical review.	A1	Claim-Service denied	MA07	<b>Alert:</b> 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
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
7004	UNITS CUTBACK. MAX # OF UNITS/WEEK(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.
7004	UNITS CUTBACK. MAX # OF UNITS/WEEK(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.
7004	UNITS CUTBACK. MAX # OF UNITS/WEEK(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.
7004	UNITS CUTBACK. MAX # OF UNITS/WEEK(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.
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 been met.	259	Frequency of service.

7005	EXCEEDS MAX UNITS ALLOWED/WEEK(S)	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum	259	Frequency of service.
7006	UNITS CUTBACK. MAX # OF UNITS/MONTH(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.
7006	UNITS CUTBACK. MAX # OF UNITS/MONTH(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.
7006	UNITS CUTBACK. MAX # OF UNITS/MONTH(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.
7006	UNITS CUTBACK. MAX # OF UNITS/MONTH(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.
7007	EXCEEDS MAX UNITS ALLOWED/MONTH(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.
7007	EXCEEDS MAX UNITS ALLOWED/MONTH(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 been met.	259	Frequency of service.
7007	EXCEEDS MAX UNITS ALLOWED/MONTH(S)	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum	259	Frequency of service.
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 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.	259	Frequency of service.
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	259	Frequency of service.
7009	EXCEEDS MAX UNITS ALLOWED/YEAR(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.
7009	EXCEEDS MAX UNITS ALLOWED/YEAR(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 been met.	259	Frequency of service.
7009	EXCEEDS MAX UNITS ALLOWED/YEAR(S)	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum	259	Frequency of service.
7010	UNITS CUTBACK. MAX # OF UNITS/LIFETIME EXCEEDED	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	258	Days-units for procedure-revenue code.
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	258	Days-units for procedure-revenue code.
7010	UNITS CUTBACK. MAX # OF UNITS/LIFETIME EXCEEDED	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.
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.





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	258	Days-units for procedure-revenue code.
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	258	Days-units for procedure-revenue code.
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	259	Frequency of service.
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	259	Frequency of service.
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.
7021	EXCEEDS MAX # UNITS FOR CAP SERVICE ALLOWED/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.
7021	EXCEEDS MAX # UNITS FOR CAP SERVICE 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.
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.	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.	N357	Time frame requirements between this service-procedure-supply and a related service-procedure-supply have not been met.	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.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount
7022	NO FURTHER PAYMENT FOR THIS SERVICE	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	107	Processed according to contract-plan provisions.
7022	NO FURTHER PAYMENT FOR THIS SERVICE	45	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges.	483	Maximum coverage amount met or exceeded for benefit period.
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
7464	Effective DOS 01/01/13 Personal Care Services billed by Adult Care Home providers must be submitted in CMS 1500 claim format. ACH billing DOS prior to	125	Submission-billing error(s)	N34	Incorrect claim form-format for this service	276	UB04-HCFA-1450-1500 claim form
7464	Effective DOS 01/01/13 Personal Care Services billed by Adult Care Home providers must be submitted in CMS 1500 claim format. ACH billing DOS prior to	125	Submission-billing error(s)	N34	Incorrect claim form-format for this service	481	Claim-submission format is invalid
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

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
7724	Diagnosis does not support billing of debridement of nails per MCD guidelines.	11	The diagnosis is inconsistent with the procedure.	M76	Missing-incomplete-invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered
7729	Diagnosis billed does not met MCD guidelines for paring and cutting of lesions or trimming of nondystrophic nails.	11	The diagnosis is inconsistent with the procedure.	M76	Missing-incomplete-invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered
7730	Only one discontinued surgical proc is 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.
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.
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.
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
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
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.

<b>8103</b>	<b>Covered days and patient status are inconsistent with bill type. Correct your bill type or patient status and resubmit</b>	<b>125</b>	Submission-billing error(s)	<b>MA130</b>	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	<b>21</b>	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
<b>8105</b>	<b>Allowed days for lower level of care in acute facility has been exceeded</b>	<b>119</b>	Benefit maximum for this time period or occurrence has been reached.	<b>N362</b>	The number of Days or Units of Service exceeds our acceptable maximum.	<b>612</b>	Per Day Limit Amount.
<b>8107</b>	<b>Therapeutic leave not reimbursable to this provider type when billing lower level of care (LLOC)</b>	<b>185</b>	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	<b>N95</b>	This provider type-provider specialty may not bill this service.	<b>91</b>	Entity not eligible-not approved for dares of service. Note-This code requires use of an Entiy Code.
<b>8020</b>	<b>Procedure is only covered for money follows ther person recipient.</b>	<b>A1</b>	Claim-Service denied	<b>M51</b>	Missing-incomplete-invalid procedure code(s).	<b>454</b>	Procedure code for services rendered.
<b>8029</b>	<b>Claim Denied. Inpatient place of service being billed and recipient is not enrolled in money follows the person (MFP)</b>	<b>A1</b>	Claim-Service denied	<b>N428</b>	Service-procedure not covered when performed in this place of service.	<b>249</b>	Place of service.
<b>8053</b>	<b>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</b>	<b>A1</b>	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.	<b>M52</b>	Missing-incomplete-invalid from date(s) of service.	<b>197</b>	Effective coverage dates.
<b>8098</b>	<b>Service denied. Exceeds allowed units within 26 days by the same or different provider</b>	<b>119</b>	Benefit maximum for this time period or occurrence has been reached.	<b>M86</b>	Service denied because payment already made for same-similar procedure within set time frame.	<b>259</b>	Frequency of service.

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.
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.
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 patient's care. Refile 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.
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.	454	Procedure code for services rendered.
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	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.

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	<b>Alert-</b> You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	286	Other payers explanation of benefits-payment information.
8700	Per Legislative Mandate this medicaid claim must be filed electronically for adjudication.	A1	Claim-Service denied	M117	Not covered unless submitted via electronic claim.	275	Claim.
8700	Per Legislative Mandate this medicaid claim must be filed electronically for adjudication.	A1	Claim-Service denied	M117	Not covered unless submitted via electronic claim.	481	Claim-submission format is invalid.
8701	Refile as an adjustment and attach medical records, operative notes, federal statements or other pertinent documentation.	16	Claim-service lacks information which is needed for adjudication	M117	Not covered unless submitted via electronic claim.	294	Supporting documentation.
8701	Refile as an adjustment and attach medical records, operative notes, federal statements or other pertinent documentation.	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes-summary-report-chart.	294	Supporting documentation.
8701	Refile as an adjustment and attach medical records, operative notes, federal statements or other pertinent documentation.	16	Claim-service lacks information which is needed for adjudication	M117	Not covered unless submitted via electronic claim.	317	Patients medical records.
8701	Refile as an adjustment and attach medical records, operative notes, federal statements or other pertinent documentation.	16	Claim-service lacks information which is needed for adjudication	N29	Missing documentation-orders-notes-summary-report-chart.	317	Patients medical records.

8702	PLEASE REFER TO CLINICAL POLICY NUMBER 1A-22 FOR COVERAGE CRITERIA FOR MEDICALLY NECESSARY CIRCUMCISIONS. RESUBMIT WITH MEDICAL RECORD DOCUMENTATION SUPPORTING CLAIM	202	Non-covered personal comfort or convenience services.	M16	<b>Alert-</b> 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	<b>Alert-</b> Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	317	Patients medical records.
8826	Payment reduced for Medicare TPL payment, paid up to the Estimated Amount Due	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N9	Adjustment represents the estimated amount a previous payer may pay.	107	Processed according to contract-plan provisions.
8826	Payment reduced for Medicare TPL payment, paid up to the Estimated Amount Due	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	107	Processed according to contract-plan provisions.
8826	Payment reduced for Medicare TPL payment, paid up to the Estimated Amount Due	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.
8826	Payment reduced for Medicare TPL payment, paid up to the Estimated Amount Due	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N9	Adjustment represents the estimated amount a previous payer may pay.	182	Allowable-paid from primary coverage
8826	Payment reduced for Medicare TPL payment, paid up to the Estimated Amount Due	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	182	Allowable-paid from primary coverage

8826	Payment reduced for Medicare TPL payment, paid up to the Estimated Amount Due	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	182	Allowable-paid from primary coverage
8827	Claim submitted indicates Medicare payment. The sum of coinsurance and deductible amounts must be placed in the estimated amount due field locator 55.	148	Information from another provider was not provided or was insufficient-incomplete	MA07	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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 <a href="http://www.cms.hhs.gov-mcd">http---www.cms.hhs.gov-mcd</a> , 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

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	<b>Alert-</b> 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.		<b>No Mapping Required</b>	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	<b>Alert-</b> 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.
9006	Claim suspended due to bad address on provider file.	133	The disposition of this claim-service is pending further review.	N258	Missing-incomplete-invalid billing provider-supplier address.	3	Claim has been adjudicated and is awaiting payment cycle.
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.	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.
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 eighth 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 eighth 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.
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.

9142	Each 1,000 units of Epogen equals 1 Medicaid unit. Medicaid units billed for this procedure must not exceed 9 units. 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.
9142	Each 1,000 units of Epogen equals 1 Medicaid unit. Medicaid units billed for this procedure must not exceed 9 units. 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
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.
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
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	<b>DRG - other diagnosis code 8 is invalid or requires further subdivision. Correct and resubmit claim.</b>	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing-incomplete-invalid other diagnosis.	256	DRG code(s).
9218	<b>DRG - other dx code equal to or greater than 9 is invalid or requires further subdivision. Correct and resubmit claim.</b>	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing-incomplete-invalid other diagnosis.	255	Diagnosis code.
9218	<b>DRG - other dx code equal to or greater than 9 is invalid or requires further subdivision. Correct and resubmit claim.</b>	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing-incomplete-invalid other diagnosis.	256	DRG code(s).
9219	<b>DRG Principal diagnosis invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines.</b>	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	<b>DRG Principal diagnosis invalid for recipient sex. If MID and DX are correct, submit claim to DMA claims analysis unit, see billing guidelines.</b>	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	<b>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</b>	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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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 invalid for recipient 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 invalid for recipient 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	<b>Alert-</b> 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 equal 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 equal 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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.
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
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
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	Eighth 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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.
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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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.		<b>No Mapping Required</b>	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		<b>No Mapping Required</b>	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		<b>No Mapping Required</b>	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	<b>Alert-</b> 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.

<b>9609</b>	<b>ER service pd in history for the same time of service and same day in which medical screening exam fee billed.</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M86</b>	Service denied because payment already made for same-similar procedure within set time frame.	<b>258</b>	Days-units for procedure-revenue code.
<b>9610</b>	<b>Medical screening exam fee recouped. ER service have been paid.</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>M86</b>	Service denied because payment already made for same-similar procedure within set time frame.	<b>259</b>	Frequency of service.
<b>9611</b>	<b>Medical Screening exam fee recouped. Service was authorized-true emergency. Refile claim for ER service.</b>	<b>45</b>	Charge exceeds fee schedule-maximum allowable or contracted-legislated fee arrangement	<b>MA67</b>	Correction to a prior claim.	<b>101</b>	Claim was processed as adjustment to previous claim.
<b>9612</b>	<b>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.</b>	<b>125</b>	Submission-billing error(s)	<b>MA130</b>	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	<b>21</b>	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
<b>9613</b>	<b>Adjustment denied: Claim processed correctly according to the Medicaid guidelines in effect at the time of the original processing.</b>	<b>193</b>	Original payment decision is being maintained. This claim was processed properly the first time	<b>N381</b>	Consult our contractual agreement for restrictions-billing-payment information related to these charges	<b>101</b>	Claim was processed as adjustment to previous claim.

9613	Adjustment denied: Claim processed correctly according to the Medicaid guidelines in effect at the time of the original processing.	193	Original payment decision is being maintained. This claim was processed properly the first time	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions.
9614	Claim denied. Provider number and-or type of bill invalid, resubmit with correct provider number and-or type of bill for services rendered.	125	Submission-billing error(s)	MA130	Your claim contains incomplete and-or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete-correct information.	21	Missing or invalid information. Note- At least one other status code is required to identify the missing or invalid information.
9615	Adj. Denied: Request is being forwarded to Provider Services. In the future, submit request of this type on a resolution inquiry form.	A1	Claim-Service denied	N34	Incorrect claim form-format for this service.	481	Claim-submission format is invalid.
9616	Adjustment request is being held pending review of medical records from all parties. Request will process at a later date, Please do not resubmit.	133	The disposition of this claim-service is pending further review.	N185	<b>Alert-</b> Do not resubmit this claim-service	317	Patients medical records.
9617	This financial transaction is to reinstate an adjustment that was previously written-off to bad-debt.	101	Predetermination: anticipated payment upon completion of services or claim adjudication.		<b>No Mapping Required</b>	38	Awaiting next periodic adjudication cycle.
9618	One evaluation allowed 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
9625	Refile inpatient crossover claim with DRG as assigned by Medicare.	A1	Claim-Service denied	N48	Claim information does not agree with information received from other insurance carrier.	256	DRG code(s).
9625	Refile inpatient crossover claim with DRG as assigned by Medicare.	A1	Claim-Service denied	N48	Claim information does not agree with information received from other insurance carrier.	275	Claim.

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

9629	Per diem; paid all Medicaid eligible days less the Medicare payment.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	65	Claim-line has been paid.
9629	Per diem; paid all Medicaid eligible days less the Medicare payment.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	65	Claim-line has been paid.
9629	Per diem; paid all Medicaid eligible days less the Medicare payment.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N192	Patient is a Medicaid-Qualified Medicare Beneficiary.	107	Processed according to contract-plan provisions
9629	Per diem; paid all Medicaid eligible days less the Medicare payment.	23	The impact of prior payer(s) adjudication including payments and-or adjustments	N381	Consult our contractual agreement for restrictions-billing-payment information related to these charges	107	Processed according to contract-plan provisions
9630	Adjustment denied. When billing for additional dates of service, file a new claim for those dates instead of filing an adjustment.	A1	Claim-Service denied	N517	Resubmit a new claim with the requested information.	481	Claim-submission format is invalid.
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.
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	<b>Alert-</b> 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.
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	<b>Alert-</b> Patient eligible to apply for other coverage which may be primary.	91	Entity not eligible-not approved for dates of service.

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)
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	<b>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</b>	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	<b>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</b>	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	<b>Claim denied by Medicare. Medicaid has already made payment for claim on a previous RA.</b>	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	<b>Claim denied by Medicare. Medicaid has already made payment for claim on a previous RA.</b>	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	<b>NAME ON MEDICARE CLAIM DOES NOT MATCH NAME ON EOMB/VOUCHER</b>	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).
9811	<b>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</b>	A1	Claim-Service denied	M52	Missing-incomplete-invalid from date(s) of service.	197	Effective coverage date(s).

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.
9904	CMS 1500 claim with more than 3 NDC's per procedure code must be billed electronically.	A1	Claim-Service denied	M117	Not covered unless submitted via electronic claim.	216	Drug information.
9904	CMS 1500 claim with more than 3 NDC's per procedure code must be billed electronically.	A1	Claim-Service denied	M117	Not covered unless submitted via electronic claim.	217	Drug name, strength and dosage form.
9904	CMS 1500 claim with more than 3 NDC's per procedure code must be billed electronically.	A1	Claim-Service denied	M117	Not covered unless submitted via electronic claim.	218	NDC number.
9930	NDC IS DESI (LESS THAN EFFECTIVE)	A1	Claim-Service denied	M16	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	218	NDC number.

9946	<b>FIFTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE</b>	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M16	<b>Alert-</b> Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	585	Denied Charge or Non-covered Charge
9947	<b>SIXTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE</b>	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M16	<b>Alert-</b> Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	218	NDC number.
9947	<b>SIXTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE</b>	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M16	<b>Alert-</b> Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	585	Denied Charge or Non-covered Charge
9948	<b>SEVENTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE</b>	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M16	<b>Alert-</b> Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	218	NDC number.
9948	<b>SEVENTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE</b>	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M16	<b>Alert-</b> Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	585	Denied Charge or Non-covered Charge
9949	<b>EIGHTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE</b>	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M16	<b>Alert-</b> 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	<b>Alert-</b> Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	585	Denied Charge or Non-covered Charge
9950	<b>NINTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE</b>	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M16	<b>Alert-</b> Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	218	NDC number.

9950	<b>NINTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE</b>	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M16	<b>Alert-</b> Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	585	Denied Charge or Non-covered Charge
9951	<b>TENTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE</b>	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M16	<b>Alert-</b> Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	218	NDC number.
9951	<b>TENTH NDC IS NON-COVERED EITHER BY DMA POLICY OR CMS MANDATE</b>	96	Non-covered charge(s). Note-Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M16	<b>Alert-</b> Please see our web site, mailings, or bulletins for more details concerning this policy-procedure-decision	585	Denied Charge or Non-covered Charge
9953	<b>PAYMENT OF PROCEDURE IS DENIED BASED ON MUE EDITING</b>	B5	Coverage-program guidelines were not met or were exceeded.		<b>No Mapping Required</b>	454	Procedure code for services rendered.
9953	<b>PAYMENT OF PROCEDURE IS DENIED BASED ON MUE EDITING</b>	B5	Coverage-program guidelines were not met or were exceeded.		<b>No Mapping Required</b>	585	Denied Charge or Non-covered Charge
9954	<b>PAYMENT OF PROCEDURE CODE IS DENIED BASED ON CORRECT CODING STANDARDS EDITING</b>	B5	Coverage-program guidelines were not met or were exceeded.		<b>No Mapping Required</b>	454	Procedure code for services rendered.
9954	<b>PAYMENT OF PROCEDURE CODE IS DENIED BASED ON CORRECT CODING STANDARDS EDITING</b>	B5	Coverage-program guidelines were not met or were exceeded.		<b>No Mapping Required</b>	585	Denied Charge or Non-covered Charge
9957	<b>Payment of procedure code is denied based on Correct Coding Standards editing regarding duplicates</b>	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	<b>Basic personal care service is not allowed for the same DOS as enhanced personal care service.</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>258</b>	Days-units for procedure-revenue code.
9959	<b>Enhanced personal care service are not allowed for the same DOS as basic personal care service. Basic personal care service recouped.</b>	<b>B15</b>	This service-procedure requires that a qualifying service-procedure be received and covered. The qualifying other service-procedure has not been received-adjudicated. Note- Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>N20</b>	Service not payable with other service rendered on the same date.	<b>258</b>	Days-units for procedure-revenue code.
9960	<b>RESUBMIT ON THE NEW UBO4 CLAIM FORM</b>	<b>A1</b>	Claim-Service denied	<b>N34</b>	Incorrect claim form-format for this service.	<b>276</b>	UB04-HCFA-1450-1500 claim form .
9960	<b>RESUBMIT ON THE NEW UBO4 CLAIM FORM</b>	<b>A1</b>	Claim-Service denied	<b>N34</b>	Incorrect claim form-format for this service.	<b>481</b>	Claim-submission format is invalid.
9961	<b>Claim recouped based on Correct Coding Standards Duplicate Editing</b>	<b>B13</b>	Previously paid. Payment for this claim-service may have been provided in a previous payment	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient	<b>101</b>	Claim was processed as adjustment to previous claim
9962	<b>Detail recouped based on Correct Coding Standards Duplicate Editing</b>	<b>B13</b>	Previously paid. Payment for this claim-service may have been provided in a previous payment	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient	<b>101</b>	Claim was processed as adjustment to previous claim
9963	<b>Claim recouped based on Correct Coding Standards Evaluation and Management Editing</b>	<b>B13</b>	Previously paid. Payment for this claim-service may have been provided in a previous payment	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient	<b>101</b>	Claim was processed as adjustment to previous claim

9964	<b>Detail recouped based on Correct Coding Standards Evaluation and Management Editing</b>	<b>B13</b>	Previously paid. Payment for this claim-service may have been provided in a previous payment	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient	<b>101</b>	Claim was processed as adjustment to previous claim
9965	<b>Claim recouped based on Correct Coding Standards Global Surgery Editing</b>	<b>B13</b>	Previously paid. Payment for this claim-service may have been provided in a previous payment	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient	<b>101</b>	Claim was processed as adjustment to previous claim
9966	<b>Detail recouped based on Correct Coding Standards Global Surgery Editing</b>	<b>B13</b>	Previously paid. Payment for this claim-service may have been provided in a previous payment	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient	<b>101</b>	Claim was processed as adjustment to previous claim
9967	<b>Claim recouped based on Correct Coding Standards New Visit Editing</b>	<b>B13</b>	Previously paid. Payment for this claim-service may have been provided in a previous payment	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient	<b>101</b>	Claim was processed as adjustment to previous claim
9968	<b>Detail recouped based on Correct Coding Standards New Visit Editing</b>	<b>B13</b>	Previously paid. Payment for this claim-service may have been provided in a previous payment	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient	<b>101</b>	Claim was processed as adjustment to previous claim
9969	<b>Claim recouped based on Correct Coding Standards Obstetric Care Editing</b>	<b>B13</b>	Previously paid. Payment for this claim-service may have been provided in a previous payment	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient	<b>101</b>	Claim was processed as adjustment to previous claim
9970	<b>Detail recouped based on Correct Coding Standards Obstetric Care Editing</b>	<b>B13</b>	Previously paid. Payment for this claim-service may have been provided in a previous payment	<b>M80</b>	Not covered when performed during the same session-date as a previously processed service for the patient	<b>101</b>	Claim was processed as adjustment to previous claim
9974	<b>Payment of procedure code is denied based on Correct Coding Standards Add-on Editing</b>	<b>B5</b>	Coverage-program guidelines were not met or were exceeded		<b>No Mapping Required</b>	<b>454</b>	Procedure code for services rendered
9974	<b>Payment of procedure code is denied based on Correct Coding Standards Add-on Editing</b>	<b>B5</b>	Coverage-program guidelines were not met or were exceeded		<b>No Mapping Required</b>	<b>585</b>	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
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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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	<b>Alert-</b> 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.
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.