EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00001	Fee Adjusted To Maximum Allowable	133	The disposition of the claim/service is pending further review. (Use only with Group Code OA)	CO	Contractual Obligations	N29	Missing documentation/orders/notes/summary/report/chart.	41	Special handling required at payer site.		
00003	Consecutive Dates Of Service Cannot Be Billed. List Each Date Separately And Resubmit	125	Submission/billing error(s). 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.)			N63	Rebill services on separate claim lines.	187	Date(s) of service.		
00004	Provider Number Missing Or Invalid. Enter Corrected Provider Number On The Claim And Submit As A New Claim	125	Submission/billing error(s). 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.)			N77	Missing/incomplete/invalid designated provider number.	132	Entity's Medicaid provider id.	1P	PROVIDER
00004	Provider Number Missing Or Invalid. Enter Corrected Provider Number On The Claim And Submit As A New Claim	125	Submission/billing error(s). 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.)			N77	Missing/incomplete/invalid designated provider number.	21	Missing or invalid information.	1P	PROVIDER
00005	Ndc Missing, Invalid Or Not On State File. Correct 11 Digi Code Required. Valid Compound Ndc /Or Compound Indicator And All Ingredient Ndc'S Required, See Pharmacy Manual	125	Submission/billing error(s). 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.)			M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	21	Missing or invalid information.		
00005	Ndc Missing, Invalid Or Not On State File. Correct 11 Digi Code Required. Valid Compound Ndc /Or Compound Indicator And All Ingredient Ndc'S Required, See Pharmacy Manual	125	Submission/billing error(s). 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.)			M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	218	NDC number.		
00009	Service Not Covered By The Medicaid Program; Pharmacy: See Non-Covered Items Under Scope Of Services In Manual	96	Non-covered charge(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00009	Service Not Covered By The Medicaid Program; Pharmacy: See Non-Covered Items Under Scope Of Services In Manual	96	Non-covered charge(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
00010	Diagnosis Or Service Invalid For Recipient Age. Verify Mid, Diagnosis, Procedure Code Or Procedure Code/Modifier Combination For Errors. Correct And Submit As A New Claim	125	Submission/billing error(s). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	21	Missing or invalid information.		
00010	Diagnosis Or Service Invalid For Recipient Age. Verify Mid, Diagnosis, Procedure Code Or Procedure Code/Modifier Combination For Errors. Correct And Submit As A New Claim	125	Submission/billing error(s). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	475	Procedure code not valid for patient age		
00010	Diagnosis Or Service Invalid For Recipient Age. Verify Mid, Diagnosis, Procedure Code Or Procedure Code/Modifier Combination For Errors. Correct And Submit As A New Claim	125	Submission/billing error(s). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	488	Diagnosis code(s) for the services rendered.		
00010	Diagnosis Or Service Invalid For Recipient Age. Verify Mid, Diagnosis, Procedure Code Or Procedure Code/Modifier Combination For Errors. Correct And Submit As A New Claim	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	21	Missing or invalid information.		
00010	Diagnosis Or Service Invalid For Recipient Age. Verify Mid, Diagnosis, Procedure Code Or Procedure Code/Modifier Combination For Errors. Correct And Submit As A New Claim	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	475	Procedure code not valid for patient age		
00010	Diagnosis Or Service Invalid For Recipient Age. Verify Mid, Diagnosis, Procedure Code Or Procedure Code/Modifier Combination For Errors. Correct And Submit As A New Claim	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered.		
00011	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.	IL	INSURED OR SUBSCRIBER
00011	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	IL	INSURED OR SUBSCRIBER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00012	Diagnosis Or Service Invalid For Recipient Sex	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	474	Procedure code and patient gender mismatch		
00012	Diagnosis Or Service Invalid For Recipient Sex	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	86	Diagnosis and patient gender mismatch.		
00013	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.			N253	Missing/incomplete/invalid attending provider primary identifier.	562	Entity's National Provider Identifier (NPI).	1P	PROVIDER
00013	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.			N253	Missing/incomplete/invalid attending provider primary identifier.	91	Entity not eligible/not approved for dates of service.	1P	PROVIDER
00013	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.					562	Entity's National Provider Identifier (NPI).	1P	PROVIDER
00013	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.					91	Entity not eligible/not approved for dates of service.	1P	PROVIDER
00014	Service Denied 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). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	297	Medical notes/report.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00018	Claim Denied. No History To Justify Time Limit Override	29	The time limit for filing has expired.			N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	294	Supporting documentation.		
00019	Primary And/Or Secondary Diagnosis Code Invalid. Verify, Correct, And Submit As A New Day Claim	9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	255	Diagnosis code.		
00021	Exact Duplicate-Same Dos/Same Procedure/Same Modifier/Same Amount	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00023	Service Requires Prior Approval	197	Precertification/authorization/notification absent.			N54	Claim information is inconsistent with pre-certified/authorized services.	84	Service not authorized.		
00024	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). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	21	Missing or invalid information.		
00024	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). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	228	Type of bill for UB claim		
00024	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). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	453	Procedure Code Modifier(s) for Service(s) Rendered		
00024	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). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00024	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). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	228	Type of bill for UB claim		
00024	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). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	453	Procedure Code Modifier(s) for Service(s) Rendered		
00027	Diagnosis Code Missing Or Invalid. Verify And Enter The Correct Diagnosis Code And Submit As A New Claim	146	Diagnosis was invalid for the date(s) of service reported.			M76	Missing/incomplete/invalid diagnosis or condition.	21	Missing or invalid information.		
00027	Diagnosis Code Missing Or Invalid. Verify And Enter The Correct Diagnosis Code And Submit As A New Claim	146	Diagnosis was invalid for the date(s) of service reported.			M76	Missing/incomplete/invalid diagnosis or condition.	255	Diagnosis code.		
00027	Diagnosis Code Missing Or Invalid. Verify And Enter The Correct Diagnosis Code And Submit As A New Claim	146	Diagnosis was invalid for the date(s) of service reported.			M76	Missing/incomplete/invalid diagnosis or condition.	477	Diagnosis code pointer is missing or invalid		
00030	Missing Or Invalid Gross Amount Due	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	M54	Missing/incomplete/invalid total charges.	178	Submitted charges.		
00034	Please Indicate Part B Medicare Payment In Form Locator 54 And Resubmit As A New Claim	148	Information from another provider was not provided or was insufficient/incomplete. 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.)			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.		
00036	Invalid Place Of Service For Procedure Or Revenue Code	125	Submission/billing error(s). 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.)			MA30	Missing/incomplete/invalid type of bill.	228	Type of bill for UB claim		
00036	Invalid Place Of Service For Procedure Or Revenue Code	125	Submission/billing error(s). 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.)			MA30	Missing/incomplete/invalid type of bill.	249	Place of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00036	Invalid Place Of Service For Procedure Or Revenue Code	125	Submission/billing error(s). 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.)			MA30	Missing/incomplete/invalid type of bill.	455	Revenue code for services rendered.		
00036	Invalid Place Of Service For Procedure Or Revenue Code	125	Submission/billing error(s). 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.)			M50	Missing/incomplete/invalid revenue code(s).	228	Type of bill for UB claim		
00036	Invalid Place Of Service For Procedure Or Revenue Code	125	Submission/billing error(s). 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.)			M50	Missing/incomplete/invalid revenue code(s).	249	Place of service.		
00036	Invalid Place Of Service For Procedure Or Revenue Code	125	Submission/billing error(s). 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.)			M50	Missing/incomplete/invalid revenue code(s).	455	Revenue code for services rendered.		
00036	Invalid Place Of Service For Procedure Or Revenue Code	125	Submission/billing error(s). 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.)			M77	Missing/incomplete/invalid place of service.	228	Type of bill for UB claim		
00036	Invalid Place Of Service For Procedure Or Revenue Code	125	Submission/billing error(s). 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.)			M77	Missing/incomplete/invalid place of service.	249	Place of service.		
00036	Invalid Place Of Service For Procedure Or Revenue Code	125	Submission/billing error(s). 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.)			M77	Missing/incomplete/invalid place of service.	455	Revenue code for services rendered.		
00040	Admission Date/Date Of Service Missing Or Invalid. Verify And Enter Correct Dos And Submit As A New Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M52	Missing/incomplete/invalid →from→ date(s) of service.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00040	Admission Date/Date Of Service Missing Or Invalid. Verify And Enter Correct Dos And Submit As A New Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M52	Missing/incomplete/invalid →from→ date(s) of service.	189	Facility admission date		
00040	Admission Date/Date Of Service Missing Or Invalid. Verify And Enter Correct Dos And Submit As A New Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M52	Missing/incomplete/invalid →from→ date(s) of service.	21	Missing or invalid information.		
00040	Admission Date/Date Of Service Missing Or Invalid. Verify And Enter Correct Dos And Submit As A New Claim	125	Submission/billing error(s). 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.)			N173	No qualifying hospital stay dates were provided for this episode of care.	187	Date(s) of service.		
00040	Admission Date/Date Of Service Missing Or Invalid. Verify And Enter Correct Dos And Submit As A New Claim	125	Submission/billing error(s). 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.)			N173	No qualifying hospital stay dates were provided for this episode of care.	189	Facility admission date		
00040	Admission Date/Date Of Service Missing Or Invalid. Verify And Enter Correct Dos And Submit As A New Claim	125	Submission/billing error(s). 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.)			N173	No qualifying hospital stay dates were provided for this episode of care.	21	Missing or invalid information.		
00041	Federal Sterilization Consent Form Required	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N3	Missing consent form.	48	Referral/authorization.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00047	Units Of Service Are Not Consistent With Dates Of Service For Physician Claims: If Dates Are Not Consecutive List Each Date Of Service On A Separate Line Correct And Resubmit	125	Submission/billing error(s). 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.)			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.		
00047	Units Of Service Are Not Consistent With Dates Of Service For Physician Claims: If Dates Are Not Consecutive List Each Date Of Service On A Separate Line Correct And Resubmit	125	Submission/billing error(s). 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.)			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		
00049	Medical Necessity Is Not Apparent	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N180	This item or service does not meet the criteria for the category under which it was billed.	287	Medical necessity for service.		
00050	From Date Of Service Is Invalid Or Greater Than The Receipt Date. Verify And Enter Correct Dos And Submit As A New Claim	110	Billing date predates service date.	CO	Contractual Obligations	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	187	Date(s) of service.	85	BILLING PROVIDER
00054	Radiation Management Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00054	Radiation Management Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00057	Dme And Orthotic Or Prosthetic Equipment Allowed Once In 2 Yrs For Ages 00-20	108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00060	Not In Accordance With Medical Policy Guidelines	B5	Coverage/program guidelines were not met or were exceeded.			MA63	Missing/incomplete/invalid principal diagnosis.	21	Missing or invalid information.		
00060	Not In Accordance With Medical Policy Guidelines	B5	Coverage/program guidelines were not met or were exceeded.					21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00065	Only Provider Of Service May Bill This Procedure/Modifier Combination	B20	Procedure/service was partially or fully furnished by another provider.			N32	Claim must be submitted by the provider who rendered the service.	84	Service not authorized.		
00066	Duplicate Payment To Other Provider	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00068	Bill Medicare Part B Carrier	22	This care may be covered by another payer per coordination of benefits.	CO	Contractual Obligations	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.		
00068	Bill Medicare Part B Carrier	22	This care may be covered by another payer per coordination of benefits.			MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	116	Claim submitted to incorrect payer.		
00069	Bill Medicare Part A Carrier	22	This care may be covered by another payer per coordination of benefits.			MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	116	Claim submitted to incorrect payer.		
00070	Receipt Date Of Claim Is Prior To The Date Of Service. Correct And Resubmit							483	Maximum coverage amount met or exceeded for benefit		
00074	Detail Billed Amount Exceeds Set Dollar Amount	125	Submission/billing error(s). 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.)			N34	Incorrect claim form/format for this service.	277	Paper claim.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00074	Detail Billed Amount Exceeds Set Dollar Amount	125	Submission/billing error(s). 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.)			N34	Incorrect claim form/format for this service.	59	Information was requested by a non-electronic method.		
00079	This Service Is Not Payable To Your Provider Taxonomy In Accordance With Medicaid Guidelines	170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N95	This provider type/provider specialty may not bill this service.	25	Entity not approved.	1P	PROVIDER
00080	Sum Of Covered Days, Non-Covered Days, And Coinsurance Days Is Greater Than Statementcovers Period Correct And Resubmit	125	Submission/billing error(s). 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.)			M53	Missing/incomplete/invalid days or units of service.	258	Days/units for procedure/revenue code.		
00080	Sum Of Covered Days, Non-Covered Days, And Coinsurance Days Is Greater Than Statementcovers Period Correct And Resubmit	125	Submission/billing error(s). 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.)			N345	Date range not valid with units submitted.	258	Days/units for procedure/revenue code.		
00081	Procedure Only Allowed Once In A Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			N117	This service is paid only once in a patient→s lifetime.	259	Frequency of service.		
00082	Service Is Not Consistent With/Or Not Covered For This Diagnosis/Or Description Does Not Match Diagnosis	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered.		
00084	Recipient Is Partially Ineligible For Service Dates. Resubmit A New Claim Billing Only Eligible Dates Of Service	141	Claim spans eligible and ineligible periods of coverage.					187	Date(s) of service.		
00084	Recipient Is Partially Ineligible For Service Dates. Resubmit A New Claim Billing Only Eligible Dates Of Service	141	Claim spans eligible and ineligible periods of coverage.					456	Covered Day(s)		
00090	Duplicate Charge Denied	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00093	Patient Deceased Per State Eligibility File. If Dos And Recipient Mid Are Correct, Submit Claim To Dma,Claims Analysis Unit, See Billing Guidelines	13	The date of death precedes the date of service.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	88	Entity not eligible for benefits for submitted dates of service.	IL	INSURED OR SUBSCRIBER
00094	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.).		
00094	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.		
00098	Fee Adjusted To Maximum Payable	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)					483	Maximum coverage amount met or exceeded for benefit period.		
00098	Fee Adjusted To Maximum Payable	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)					65	Claim/line has been paid.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00105	Date Of Service Is Prior To Date Of Birth. If Dos 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.					158	Entity's date of birth.	IL	INSURED OR SUBSCRIBER
00105	Date Of Service Is Prior To Date Of Birth. If Dos 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.					88	Entity not eligible for benefits for submitted dates of service.	IL	INSURED OR SUBSCRIBER
00120	Recipient Mid Number Missing. Enter Mid And Submit As A New Claim	125	Submission/billing error(s). 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.)			MA61	Missing/incomplete/invalid social security number or health insurance claim number.	21	Missing or invalid information.		
00120	Recipient Mid Number Missing. Enter Mid And Submit As A New Claim	125	Submission/billing error(s). 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.)			MA61	Missing/incomplete/invalid social security number or health insurance claim number.	478	Claim submitter's identifier		
00122	Service Requires Out Of State Prior Approval	197	Precertification/authorization/notification absent.			N54	Claim information is inconsistent with pre-certified/authorized services.	187	Date(s) of service.		
00122	Service Requires Out Of State Prior Approval	197	Precertification/authorization/notification absent.			N54	Claim information is inconsistent with pre-certified/authorized services.	84	Service not authorized.		
00128	Services Not Approved By Dental Consultant	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			N10	Payment 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.	IL	INSURED OR SUBSCRIBER
00129	No Patient Liability On Claim For Partial Month Billing	142	Monthly Medicaid patient liability amount.			N58	Missing/incomplete/invalid patient liability amount.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00131	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. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N163	Medical record does not support code billed per the code definition.	294	Supporting documentation.		
00131	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. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N163	Medical record does not support code billed per the code definition.	297	Medical notes/report.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00131	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. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N163	Medical record does not support code billed per the code definition.	317	Patient's medical records.		
00131	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. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	294	Supporting documentation.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00131	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. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	297	Medical notes/report.		
00131	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. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	317	Patient's medical records.		
00132	Rebill With Patient Liability Amount And/Or Correct Admission Date	125	Submission/billing error(s). 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.)			MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	189	Facility admission date		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00132	Rebill With Patient Liability Amount And/Or Correct Admission Date	125	Submission/billing error(s). 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.)			N58	Missing/incomplete/invalid patient liability amount.	189	Facility admission date		
00133	Enter Correct Bill Type In Form Locator 4 And Submit As A New Claim	125	Submission/billing error(s). 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.)			MA30	Missing/incomplete/invalid type of bill.	21	Missing or invalid information.		
00135	Patient Status Missing/Not In Accordance With Medicaid Policy/Inconsistent With Days/Dates Billed	125	Submission/billing error(s). 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.)			MA43	Missing/incomplete/invalid patient status.	21	Missing or invalid information.	QC	PATIENT
00135	Patient Status Missing/Not In Accordance With Medicaid Policy/Inconsistent With Days/Dates Billed	125	Submission/billing error(s). 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.)			MA43	Missing/incomplete/invalid patient status.	431	Patient's condition/functional status at time of service.	QC	PATIENT
00135	Patient Status Missing/Not In Accordance With Medicaid Policy/Inconsistent With Days/Dates Billed	125	Submission/billing error(s). 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.)			MA43	Missing/incomplete/invalid patient status.	90	Entity not eligible for medical benefits for submitted dates of service.	QC	PATIENT
00139	Services Limited Presumptive Eligibility	177	Patient has not met the required eligibility requirements.			N30	Patient ineligible for this service.	56	Awaiting eligibility determination.		
00142	Claim Denied. Procedure Service Only Allowed By State Optical Contractor	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N95	This provider type/provider specialty may not bill this service.	91	Entity not eligible/not approved for dates of service.	OD	DOCTOR OF OPTOMETRY
00143	Medicaid Id Number Not On State Eligibility File	31	Patient cannot be identified as our insured.					33	Subscriber and subscriber id not found.	IN	INSURER
00143	Medicaid Id Number Not On State Eligibility File	31	Patient cannot be identified as our insured.					97	Patient eligibility not found with entity.	IN	INSURER
00153	Ancillary Charges Included In Per Diem Rate	125	Submission/billing error(s). 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.)			M2	Not paid separately when the patient is an inpatient.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00156	Laboratory Revenue Code Requires Corresponding Lab Cpt Code Enter Cpt Code And Submit As A New Claim	125	Submission/billing error(s). 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.)			M51	Missing/incomplete/invalid procedure code(s).	454	Procedure code for services rendered.		
00156	Laboratory Revenue Code Requires Corresponding Lab Cpt Code Enter Cpt Code And Submit As A New Claim	125	Submission/billing error(s). 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.)			M51	Missing/incomplete/invalid procedure code(s).	455	Revenue code for services rendered.		
00158	This Revenue Code Requires A Cpt Laboratory Procedure Code	125	Submission/billing error(s). 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.)			M51	Missing/incomplete/invalid procedure code(s).	454	Procedure code for services rendered.		
00158	This Revenue Code Requires A Cpt Laboratory Procedure Code	125	Submission/billing error(s). 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.)			M51	Missing/incomplete/invalid procedure code(s).	455	Revenue code for services rendered.		
00160	Medicare Part D Eligible (Pos)	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.		
00163	Dme Providers Must Bill Modifiers. Please Correct And Resubmit	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations			453	Procedure Code Modifier(s) for Service(s) Rendered		
00163	Dme Providers Must Bill Modifiers. Please Correct And Resubmit							88	Entity not eligible for benefits for submitted	IL	INSURED OR SUBSCRIBER
00170	Tbd-Clia Certification Missing	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	MA120	Missing/incomplete/invalid CLIA certification number.	544	Clinical Laboratory Improvement Amendment		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00171	Through Date Of Service Invalid Or Greater Than Receipt Date. Verify And Enter Correct Through Dos And Submit As A New Claim	125	Submission/billing error(s). 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.)	CO	Contractual Obligations			190	Facility discharge date		
00171	Through Date Of Service Invalid Or Greater Than Receipt Date. Verify And Enter Correct Through Dos And Submit As A New Claim							88	Entity not eligible for benefits for submitted dates of service.	IL	INSURED OR SUBSCRIBER
00182	All Claims Suspended Pending Financial Review	133	The disposition of the claim/service is pending further review. (Use only with Group Code OA)			N187	Alert: You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	46	Internal review/audit.		
00186	Tooth Surface Missing Or Invalid. Correct Detail And Resubmit Claim	125	Submission/billing error(s). 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.)			N75	Missing/incomplete/invalid tooth surface information.	21	Missing or invalid information.		
00187	Quadrant Or Arch Indicator Missing Or Invalid	125	Submission/billing error(s). 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.)			N37	Missing/incomplete/invalid tooth number/letter.	21	Missing or invalid information.		
00187	Quadrant Or Arch Indicator Missing Or Invalid	125	Submission/billing error(s). 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.)			N37	Missing/incomplete/invalid tooth number/letter.	245	Dental quadrant/arch.		
00191	Medicaid Id Number Does Not Match Patient Name	140	Patient/Insured health identification number and name do not match.			MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.	30	Subscriber and subscriber id mismatched.		
00202	Revenue Code Must Be Billed With A Dme/Medical Supply Hcpc Code	125	Submission/billing error(s). 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.)			M20	Missing/incomplete/invalid HCPCS.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00202	Revenue Code Must Be Billed With A Dme/Medical Supply Hcpc Code	125	Submission/billing error(s). 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.)			M20	Missing/incomplete/invalid HCPCS.	507	HCPCS		
00202	Revenue Code Must Be Billed With A Dme/Medical Supply Hcpc Code	125	Submission/billing error(s). 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.)			M50	Missing/incomplete/invalid revenue code(s).	21	Missing or invalid information.		
00202	Revenue Code Must Be Billed With A Dme/Medical Supply Hcpc Code	125	Submission/billing error(s). 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.)			M50	Missing/incomplete/invalid revenue code(s).	507	HCPCS		
00209	Limited Oral Evaluation - Problem Focused Not Allowed Same Date Of Service As Dental Exam	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00211	Dates Of Service Not Within Authorized Time Period	197	Precertification/authorization/notification absent.			N54	Claim information is inconsistent with pre-certified/authorized services.	187	Date(s) of service.		
00213	No Prior Approval On File	197	Precertification/authorization/notification absent.	CO	Contractual Obligations	M62	Missing/incomplete/invalid treatment authorization code.	21	Missing or invalid information.	IN	INSURER
00213	No Prior Approval On File	197	Precertification/authorization/notification absent.	CO	Contractual Obligations	M62	Missing/incomplete/invalid treatment authorization code.	252	Authorization/certification number. This change effective 11/1/2011: Entity's authorization/certification number	IN	INSURER
00216	Lab Services Have Been Billed And Paid To A Pathologist Or An Independent Lab	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00220	Resubmit As An Adjustment With Ambulance Call Reports To Justify Same Day One-Way And Round Trip Transports	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	297	Medical notes/report.		
00220	Resubmit As An Adjustment With Ambulance Call Reports To Justify Same Day One-Way And Round Trip Transports	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	337	Ambulance certification/documentation.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00220	Resubmit As An Adjustment With Ambulance Call Reports To Justify Same Day One-Way And Round Trip Transports	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	472	Ambulance Run Sheet		
00220	Resubmit As An Adjustment With Ambulance Call Reports To Justify Same Day One-Way And Round Trip Transports	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	297	Medical notes/report.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00220	Resubmit As An Adjustment With Ambulance Call Reports To Justify Same Day One-Way And Round Trip Transports	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	337	Ambulance certification/documentation.		
00220	Resubmit As An Adjustment With Ambulance Call Reports To Justify Same Day One-Way And Round Trip Transports	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	472	Ambulance Run Sheet		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00220	Resubmit As An Adjustment With Ambulance Call Reports To Justify Same Day One-Way And Round Trip Transports	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	297	Medical notes/report.		
00220	Resubmit As An Adjustment With Ambulance Call Reports To Justify Same Day One-Way And Round Trip Transports	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	337	Ambulance certification/documentation.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00220	Resubmit As An Adjustment With Ambulance Call Reports To Justify Same Day One-Way And Round Trip Transports	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	472	Ambulance Run Sheet		
00224	Follow-Up Visits And Consults Not Allowed Same Day As Dialysis Treatment	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00228	Service Included In Previously Paid Cystoscopy 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.		
00229	Previously Paid Procedure 52005 Is Included In This Service. Please Refile As An Adjustment	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00229	Previously Paid Procedure 52005 Is Included In This Service. Please Refile As An Adjustment	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	454	Procedure code for services rendered.		
00230	Previously Paid Procedure 52000 Is Included In This Service. Please Refile As An Adjustment	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00230	Previously Paid Procedure 52000 Is Included In This Service. Please Refile As An Adjustment	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	454	Procedure code for services rendered.		
00231	Substance Abuse Intensive Outpatient Program (Saiop) Is Not Allowed Same Date Of Service As Partial Hospitalization And/Or Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
00237	Total Billed Does Not Equal The Sum Of Details Billed	125	Submission/billing error(s). 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.)			M54	Missing/incomplete/invalid total charges.	187	Date(s) of service.		
00237	Total Billed Does Not Equal The Sum Of Details Billed	125	Submission/billing error(s). 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.)			M54	Missing/incomplete/invalid total charges.	21	Missing or invalid information.		
00238	Prior Approval Is Required For Ach Services	197	Precertification/authorization/notification absent.	CO	Contractual Obligations			21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00238	Prior Approval Is Required For Ach Services	197	Precertification/authorization/notification absent.	CO	Contractual Obligations			252	Authorization/certification number. This change effective 11/1/2011: Entity's authorization/certification number		
00239	Follow-Up Visits Or Consults Recouped. Follow-Up Visit Or Consult Not Allowed Same Date Of Service As Dialysis Treatment	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00249	Pended For Medical Review	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.			M50	Missing/incomplete/invalid revenue code(s).	455	Revenue code for services rendered.		
00249	Pended For Medical Review										
00259	Non-Ionic Contrast Media Allowed 4 Units Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00259	Non-Ionic Contrast Media Allowed 4 Units Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00259	Non-Ionic Contrast Media Allowed 4 Units Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
00259	Non-Ionic Contrast Media Allowed 4 Units Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
00261	Removal And Insertion Of Norplant System Included In Service Fee	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00262	Service Fee Includes Removal And Insertion Of Norplant System	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00269	Bill Medicare Part A Carrier	22	This care may be covered by another payer per coordination of benefits.	CO	Contractual Obligations	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.		
00270	Billing Provider Is Not The Recipient'S Carolina Access Pcp, Authorization Is Missing Or Unresolved. Contact Pcp For Authorization Or Csc Provider Services If Authorization Is Correct	38	Services not provided or authorized by designated (network/primary care) providers.			N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	252	Authorization/certification number. This change effective 11/1/2011: Entity's authorization/certification number	85	BILLING PROVIDER
00270	Billing Provider Is Not The Recipient'S Carolina Access Pcp, Authorization Is Missing Or Unresolved. Contact Pcp For Authorization Or Csc Provider Services If Authorization Is Correct	38	Services not provided or authorized by designated (network/primary care) providers.			N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	93	Entity is not selected primary care provider.	85	BILLING PROVIDER
00286	Incorrect Authorization Number On Claim Form. Verify Number And Refile Claim					MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	252	Authorization/certification number. This change effective 11/1/2011: Entity's authorization/certification number.	85	BILLING PROVIDER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00286	Incorrect Authorization Number On Claim Form. Verify Number And Refile Claim					MA130	Your claim contains incomplete and/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	85	BILLING PROVIDER
00292	Qualified Medicare Bene-Mqb Recipient. Medicare Payment Mus 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 provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)		
00292	Qualified Medicare Bene-Mqb Recipient. Medicare Payment Mus 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.		
00292	Qualified Medicare Bene-Mqb Recipient. Medicare Payment Mus 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		
00292	Qualified Medicare Bene-Mqb Recipient. Medicare Payment Mus 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 provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00292	Qualified Medicare Bene-Mqb Recipient. Medicare Payment Mus 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.		
00292	Qualified Medicare Bene-Mqb Recipient. Medicare Payment Mus 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		
00301	Physician Visit Not Allowed Same Day As Health Check Screen By Same Provider Or Member Of Same Group. Resubmit As An Adjustment With Documentation Supporting Related Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00301	Physician Visit Not Allowed Same Day As Health Check Screen By Same Provider Or Member Of Same Group. Resubmit As An Adjustment With Documentation Supporting Related Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	294	Supporting documentation.		
00303	Initial Reline Or Adjustment Of Complete Upper Dentures Not Allowed Until 6 Months After Receipt Of Dentures Per State Limit	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00304	Initial Reline Or Adjustment Of Partial Upper Dentures Not Allowed Until 6 Months After Receipt Of Dentures Per State Limit	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00305	Panorex Not Allowed In Conjunction With Full Mouth Series	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00306	Core Buildup, Pin Retention, And Composite Or Amalgam Build Up Not Allowed On The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00307	Initial Reline Or Adjustment Of Complete Lower Dentures Not Allowed Until 6 Months After Receipt Of Dentures Per State Limit	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00310	Hospital And Psychiatric Visits Not Allowed On The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M22	Missing/incomplete/invalid number of miles traveled.	258	Days/units for procedure/revenue code.		
00311	Initial Reline Or Adjustment Of Partial Lower Dentures Not Allowed Until 6 Months After Receipt Of Dentures Per State Limit	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00312	Surgery Fee Includes Charges For Casting/Bracing	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00313	Surgery Fee Includes Cast Fee	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00314	Surgery Fee Includes Cast Fee	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00315	Surgery Fee Includes Cast Fee	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00316	Special Services Denied. Circumstances For Use Of This Procedure Or Procedure/Modifier Combination Are Not Substantiated On The Claim/Records	125	Submission/billing error(s). 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.)			N188	The approved level of care does not match the procedure code submitted.	21	Missing or invalid information.		
00316	Special Services Denied. Circumstances For Use Of This Procedure Or Procedure/Modifier Combination Are Not Substantiated On The Claim/Records	125	Submission/billing error(s). 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.)			N188	The approved level of care does not match the procedure code submitted.	453	Procedure Code Modifier(s) for Service(s) Rendered		
00317	File Adjustment Using Cbc Code That Includes All Components Billed And Combine Charges	125	Submission/billing error(s). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	21	Missing or invalid information.		
00318	Initial And/Or Established Office Visit Is Included In Fee For Service. Please Resubmit As An Adjustment	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00318	Initial And/Or Established Office Visit Is Included In Fee For Service. Please Resubmit As An Adjustment	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00319	Point Of Origin Code Submitted Is Missing Or Is Not In Accordance With Medicaid Policy. Rebill With Correct Source Of Admission Code. Refer To Ub Manual	125	Submission/billing error(s). 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.)			MA42	Missing/incomplete/invalid admission source.	21	Missing or invalid information.		
00319	Point Of Origin Code Submitted Is Missing Or Is Not In Accordance With Medicaid Policy. Rebill With Correct Source Of Admission Code. Refer To Ub Manual	125	Submission/billing error(s). 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.)			MA42	Missing/incomplete/invalid admission source.	229	Hospital admission source.		
00320	Psychiatric And Hospital Visits Not Allowed On The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M22	Missing/incomplete/invalid number of miles traveled.	258	Days/units for procedure/revenue code.		
00323	Hospital And Office Visits Not Allowed Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M22	Missing/incomplete/invalid number of miles traveled.	258	Days/units for procedure/revenue code.		
00324	Office And Hospital Visits Not Allowed Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M22	Missing/incomplete/invalid number of miles traveled.	258	Days/units for procedure/revenue code.		
00325	Procedure, Procedure/Modifier Combination Or Rate Invalid For This Date Of Service	96	Non-covered charge(s). 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.) 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00325	Procedure, Procedure/Modifier Combination Or Rate Invalid For This Date Of Service	96	Non-covered charge(s). 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.) 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.		
00328	Multiple Panel Test Codes Billed On Same Day To Equivalent Panel Test 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.		
00330	Miscellaneous Charges Not Allowed With Prolonged Services Or Critical Care	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00332	Eeg/Ecg/Ekg Recordings Included In Circadian Respiratory Pattern Recording	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 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.		
00334	Initial And Established 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00337	Critical Care And Icu Follow-Up Not Allowed Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00338	Biopsy Of Cervix Included In Colposcopy/Culdoscopy	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00339	Icu Follow-Up And Critical Care Not Allowed Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00340	Dilation Of Cervical Canal/Dilation And Currettage Included In Biopsy Of Cervix, Circumferential Cone With Or Without Dilation And Currettage	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00343	Colposcopy/Culdoscopy Includes Biopsy. Resubmit As An Adjustment	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00343	Colposcopy/Culdoscopy Includes Biopsy. Resubmit As An Adjustment	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	454	Procedure code for services rendered.		
00344	Submit Claim Using Established Eye Exam Code	125	Submission/billing error(s). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	21	Missing or invalid information.		
00345	Charges For Casting/Bracing Is Included In Surgery Fee	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00346	Charges For Cast Included In Surgery Fee	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00347	Charges For Cast Included In Surgery Fee	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00348	Charges For Cast Included In Surgery Fee	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00349	Health Check Screen And Related Service Not Allowed Same Day. Resubmit As An Adjustment With Documentation Supporting Related Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	258	Days/units for procedure/revenue code.		
00349	Health Check Screen And Related Service Not Allowed Same Day. Resubmit As An Adjustment With Documentation Supporting Related Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00351	Prophylaxis With Fluoride Fee Includes Prophylaxis Charges	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 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.		
00352	Chemonucleolysis And Laminectomy Cannot Be Billed Within One Year Of Each Other	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00355	Prolonged Services And Critical Care Not Allowed With Daily Care Or Misc Charges	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00357	Maternity Charge Allowed Once Per Gestation Period. Resubmit As An Adjustment With Medical Records To Support Multiple Or Reoccurring Gestation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00358	Only One Nail Debridement Allowed Per 60 Day Period	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00359	Individual Components Recouped. Hematology Panel That Includes Components Already Paid	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00360	Carbon Dioxide Determination Included In Fee For Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00362	Bitewings Already Billed Within 12 Calendar Months, Not A Part Of An Intraoral Complete Series (Including Bitewings)	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00362	Bitewings Already Billed Within 12 Calendar Months, Not A Part Of An Intraoral Complete Series (Including Bitewings)	119	Benefit maximum 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.		
00362	Bitewings Already Billed Within 12 Calendar Months, Not A Part Of An Intraoral Complete Series (Including Bitewings)	119	Benefit maximum for this time period or occurrence has been reached.			N59	Please refer to your provider manual for additional program and provider information.	259	Frequency of service.		
00362	Bitewings Already Billed Within 12 Calendar Months, Not A Part Of An Intraoral Complete Series (Including Bitewings)	119	Benefit maximum for this time period or occurrence has been reached.			N59	Please refer to your provider manual for additional program and provider information.	483	Maximum coverage amount met or exceeded for benefit period.		
00363	Not In Accordance With Medical Policy Guidelines	B5	Coverage/program guidelines were not met or were exceeded.					21	Missing or invalid information.		
00364	Not In Accordance With Medical Policy Guidelines	B5	Coverage/program guidelines were not met or were exceeded.					21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00365	Office Visit And/Or Consultations Are Included In Eye Exam	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00366	Delivery (With Or Without Postpartum Care) Is Included In Total Ob Package	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00367	Semen Analysis Included In Fee For Sterilization	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00368	Multiple Consultations Not Allowed Same Date Of Service, Same Provider Taxonomy Qualifier	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00369	Multiple Office Visits Not Allowed Same Date Of Service, Same Provider Taxonomy Qualifier	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00370	Multiple Hospital Visits Not Allowed Same Dos, Same Provider Taxonomy Qualifier	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00371	Supplies Are Included In Fee For Surgery	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00372	One Supply Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00372	One Supply Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00373	Consults And Hospital Visits Not Allowed Same Dos, Same Provider Taxonomy Qualifier	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M22	Missing/incomplete/invalid number of miles traveled.	258	Days/units for procedure/revenue code.		
00374	Consults And Office Visits Not Allowed Same Date Of Service, Same Provider Taxonomy Qualifier	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00375	Exploratory Laparotomy Included In Fee For Surgery	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00376	Routine Labs Are Included In Dialysis Fees	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00377	Routine Labs Are Included In Dialysis Fees	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00380	Supplies Not Allowed With Health Check Fee	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00381	Health Check Reimbursement Not Allowed On Same Day Of Service As Supplies Paid Previously	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00382	Operative Records Received Have No Dates Of Service Or Conflicting Dates Of Service, Correct Claim And/Or Records And Resubmit Both As An Adjustment	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	187	Date(s) of service.		
00382	Operative Records Received Have No Dates Of Service Or Conflicting Dates Of Service, Correct Claim And/Or Records And Resubmit Both As An Adjustment	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
00382	Operative Records Received Have No Dates Of Service Or Conflicting Dates Of Service, Correct Claim And/Or Records And Resubmit Both As An Adjustment	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	298	Operative report.		
00383	Salpingo-Oophorectomy Included In Hysterectomy Code, Resubmit As An Adjustment With Appropriate Medical Records	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	287	Medical necessity for service.		
00383	Salpingo-Oophorectomy Included In Hysterectomy Code, Resubmit As An Adjustment With Appropriate Medical Records	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	294	Supporting documentation.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00383	Salpingo-Oophorectomy Included In Hysterectomy Code, Resubmit As An Adjustment With Appropriate Medical Records	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00384	Circadian Respiratory Pattern Includes Eeg, Ecg, And Ekg Recordings. Resubmit As An Adjustment	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00385	I&D Included In Appendectomy	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00386	Office Visit Or Consult Already Paid In History. Resubmit As A Adjustment	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00387	Daily And/Or Weekly Cobalt Therapy Cannot Be Billed Multiple Times On Same Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00388	Periodontal Scaling And Root Planing, Full Mouth Debridement To Enable Comprehensive Periodontal Evaluation And Diagnosis, And Perio- Dontal Maintenance Is Included In Fee For Periodontal Surgery	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00390	Hospital Visits And Consults Not Allowed Same Date Of Service, Same Provider Taxonomy Qualifier	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M22	Missing/incomplete/invalid number of miles traveled.	258	Days/units for procedure/revenue code.		
00391	Fetal Monitoring Denied, Reimbursement Has Been Made To Hospital	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00394	Not In Accordance With Medical Policy Guidelines	B5	Coverage/program guidelines were not met or were exceeded.					258	Days/units for procedure/revenue		
00395	Delivery Of Placenta, External Cephalic Version, Or Special Miscellaneous Services Are Included In The Fee For Delivery	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00396	Carbon Dioxide Determination Included In Fee For Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00397	Dilation And Curettage Included In Biopsy Of Cervix, Circumferential Cone With Or Without D&C. Resubmit As An Adjustment	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00397	Dilation And Curettage Included In Biopsy Of Cervix, Circumferential Cone With Or Without D&C. Resubmit As An Adjustment	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00398	Immunizations Covered Only In Health Check For Recipients Under 21	6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					91	Entity not eligible/not approved for dates of service.	IL	INSURED OR SUBSCRIBER
00399	Office Visits And Consults Not Allowed Same Date Of Service, Same Provider Taxonomy Qualifier	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00400	Admission/Medical Visits/Observation Unit Not Allowed Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00401	Medical Visits/Observation Unit Not Allowed Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00402	Observation Unit/Medical Visits Not Allowed Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00403	Medical Visits/Admission Not Allowed Same Day As Initial Observation	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00404	Personal Care Service Not Allowed Same Day As Home Health Aide Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00405	Home Health Aide Services Not Allowed Same Day As Personal Care Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00407	Medical Visits/Epidural Follow-Up Not Allowed On The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00409	Epidural Follow-Up/Medical Visits Not Allowed On The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00412	Blood Gases Included In Fee For Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00413	Blood Gases Included In Fee For Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00414	Routine/Continuous Home Care/ Inpatient Respite Care/General Inpatient Care Not Allowed Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00415	Routine Continuous Home Care/Inpatient Respite Care/General Inpatient Care Not Allowed Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00416	Routine Home Care/General Respite Care/General Inpatient Care Cannot Be Billed On Same Date Of Service As Continuous Home Care	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00417	Routine Home Care/Inpatient Respite Care/General Inpatient Care Not Allowed Same Date Of Service As Continuous Home Care	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M22	Missing/incomplete/invalid number of miles traveled.	258	Days/units for procedure/revenue code.		
00418	General Inpatient Care Not Allowed Same Day As Routine Home Care/Continuous Home Care/Inpatient Respite Care/ Hospice- Long Term Care	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M22	Missing/incomplete/invalid number of miles traveled.	258	Days/units for procedure/revenue code.		
00419	Routine Home Care/Continous Home Care/General Inpatient Care/Hospice-Long Term Care Not Allowed Same Day As Inpatient Respite Care	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00420	Routine Home Care/Continous Home Care/Inpatient Respite Care/Hospice-Long Term Care Not Allowed Same Day As General Inpatient Care	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00421	Inpatient Respite Care Not Allowed Same Day As Routine Home Care/Continous Home Care/General Inpatient Care/Hospice-Long Term Care	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00422	Only One Routine Home 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.	259	Frequency of service.		
00422	Only One Routine Home 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		
00423	Only One Inpatient 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.	259	Frequency of service.		
00423	Only One Inpatient 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		
00428	Admission Type 2-Urgent Not Acceptable For Inpatient Psychiatric Admission	125	Submission/billing error(s). 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.)			MA41	Missing/incomplete/invalid admission type.	21	Missing or invalid information.		
00434	Components Of Code 52285 Have Been Billed And Paid Separately, File Adjustment If Necessary	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00435	Combine Codes/Charges And Bill To The All Inclusive Code 52285	125	Submission/billing error(s). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	21	Missing or invalid information.		
00436	Substance Abuse Intensive Outpatient Program(Saiop) Is Not Allowed Same Date Of Service As Partial Hospitalization And/Or Day Treatment	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00438	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.		
00438	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)		
00439	Information On Value Code/Value Amount Is Missing Or Incomplete. Rebill With Complete Value Code Data. Refer To Ub Manual	125	Submission/billing error(s). 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.)			M49	Missing/incomplete/invalid value code(s) or amount(s).	123	Additional information requested from entity.	85	BILLING PROVIDER
00439	Information On Value Code/Value Amount Is Missing Or Incomplete. Rebill With Complete Value Code Data. Refer To Ub Manual	125	Submission/billing error(s). 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.)			M49	Missing/incomplete/invalid value code(s) or amount(s).	21	Missing or invalid information.	85	BILLING PROVIDER
00439	Information On Value Code/Value Amount Is Missing Or Incomplete. Rebill With Complete Value Code Data. Refer To Ub Manual	125	Submission/billing error(s). 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.)			M49	Missing/incomplete/invalid value code(s) or amount(s).	726	NUBC Value Code Amount(s)	85	BILLING PROVIDER
00441	Suspect Duplicate-Same Dos/Billed Amount, Institutional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00442	Outpatient 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00443	Inpatient Claim Paid; Previously Paid Outpatient Claim Will Be Recouped	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M22	Missing/incomplete/invalid number of miles traveled.	258	Days/units for procedure/revenue code.		
00445	Hit Services Not Allowed Same Day As 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.			M22	Missing/incomplete/invalid number of miles traveled.	258	Days/units for procedure/revenue code.		
00448	Inpatient Services Paid; Previously Paid Hit Services Will Be Recouped					M22	Missing/incomplete/invalid number of miles traveled.	258	Days/units for procedure/revenue code.		
00449	Hiv Case Management Denied Due To Inpatient Claim Paid With Same Date Of Service. Case Management Fee Is Included In The Hospital Inpatient Per Diem	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M22	Missing/incomplete/invalid number of miles traveled.	454	Procedure code for services rendered.		
00453	Less Severe Duplicate- Same Provider/4 Digit Procedure Match/Dos, Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00454	Debridement Only Allowed When Billed On The Same Day As Surgical Cleansing Of Skin	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
00454	Debridement Only Allowed When Billed On The Same Day As Surgical Cleansing Of Skin	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
00455	Biopsy Of Skin Only Allowed When Billed On The Same Day As Biopsy Of Skin Lesion	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
00457	Avulsions Of Nail Plate Only Allowed When Billed On The Same Day As Removal Of Nail	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
00457	Avulsions Of Nail Plate Only Allowed When Billed On The Same Day As Removal Of Nail	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
00458	Less Severe Duplicate-Same Procedure Code, Professional/Dental	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00460	Exact Duplicate-Same Provider/Billed Amt/Dos/Procedure Code	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00462	Inpatient Claim Must Include Outpatient Charges Incurred Within 24 Hrs Of Admission. Outpatient Charges Billed Separately Have Been Denied Or Recouped. Correct & 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	Missing/incomplete/invalid number of miles traveled.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00463	Tattooing Only Allowed When Billed On The Same Day As Correct Skin Color Defects	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		
00463	Tattooing Only Allowed When Billed On The Same Day As Correct Skin Color Defects	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		
00465	Outpatient Charges Within 24 Hrs Of Admission Not Paid Separately. Add Charges To Inpatient Claim & Resubmit Replacement Claim. If Multiple Encounter, Bill Others Not 24 Hrs Of Admission, 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.		
00466	Full Thickness Graft, Each Additional 20 Sq Cm Must Bill With 20 Sq Cm Or Less	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
00466	Full Thickness Graft, Each Additional 20 Sq Cm Must Bill With 20 Sq Cm Or Less	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
00469	Suspect Duplicate- Overlapping Dates Of Service, Institutional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00470	Suspect Duplicate-Overlapping Dates Of Service, Institutional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00471	Suspect Duplicate-Overlapping Dates Of Service, Same Billing Provider, Institutional	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 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.		
00472	Suspect Duplicate-Overlapping Dates Of Service, Institutional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00474	Suspect Duplicate-Overlapping Dates Of Service, Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00475	Suspect Duplicate-Exact Service Date, Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00476	Suspect Duplicate-Same Procedure/Date Of Service, Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00478	Suspect Duplicate-Overlapping Procedures/Date Of Service, Dental	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00480	Less Severe Duplicate- Same Provider/Procedure/Overlapping Dates Of Service, Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00481	Less Severe Duplicate- Same Provider/Procedure/Revenue Code/Hour/Overlapping Date Of Service, Outpatient	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00482	Less Severe Duplicate- Same Provider/Overlapping Date Of Service, Institutional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00483	Less Severe Duplicate-Same Provider/Overlapping Date Of Service, Institutional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00484	Less Severe Duplicate-Same Provider/Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00485	Less Severe Duplicate- Same Provider/Overlapping Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00486	Less Severe Duplicate- Same Provider/Date Of Service/Internal Modifier	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00487	Less Severe Duplicate-Same Provider/Date Of Service/Internal Modifier/3 Digit Procedure Match	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00488	Less Severe Duplicate-Dental	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00490	Duplicate Claim-Same Billing Provider Number/Generic Code Number/Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00491	Duplicate Claim-Same Billing Provider Number/Prescription Number/Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00492	Exact Duplicate-Same Provider/Billed Amount/Overlapping Date Of Service, Institutional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00493	Exact Duplicate-Same Provider/Billed Amount/Date Of Service, Institutional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00498	Exact Duplicate-Same Provider/Procedure/Billed Amount/Internal Modifier, Dental	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00500	Routine Follow Up Care Included In Surgical Fee	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00502	Cap Limitation Has Been Exceeded	B5	Coverage/program guidelines were not met or were exceeded.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
00502	Cap Limitation Has Been Exceeded	B5	Coverage/program guidelines were not met or were exceeded.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
00504	Bone Survey Allowed Once Annually For Crd	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.		
00508	Bitewing X-Rays Allowed Once Within 12 Calendar Months	119	Benefit maximum for this time period or occurrence has been reached.			M90	Not covered more than once in a 12 month period.	259	Frequency of service.		
00508	Bitewing X-Rays Allowed Once Within 12 Calendar Months	119	Benefit maximum for this time period or occurrence has been reached.			M90	Not covered more than once in a 12 month period.	483	Maximum coverage amount met or exceeded for benefit		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00508	Bitewing X-Rays Allowed Once Within 12 Calendar Months	119	Benefit maximum for this time period or occurrence has been reached.			N59	Please refer to your provider manual for additional program and provider information.	259	Frequency of service.		
00508	Bitewing X-Rays Allowed Once Within 12 Calendar Months	119	Benefit maximum for this time period or occurrence has been reached.			N59	Please refer to your provider manual for additional program and provider information.	483	Maximum coverage amount met or exceeded for benefit period.		
00512	Cap Limitation For Respite Care Has Been Exceeded	B5	Coverage/program guidelines were not met or were exceeded.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
00512	Cap Limitation For Respite Care Has Been Exceeded	B5	Coverage/program guidelines were not met or were exceeded.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
00513	Inpatient Respite Care, Rc655 Not Allowed More Than 5 Consecutive Days. Split And Rebill All Subsequent Days Of Hospital Stay As Rc651 Routine Home Care	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M53	Missing/incomplete/invalid days or units of service.	258	Days/units for procedure/revenue code.		
00513	Inpatient Respite Care, Rc655 Not Allowed More Than 5 Consecutive Days. Split And Rebill All Subsequent Days Of Hospital Stay As Rc651 Routine Home Care	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N61	Rebill services on separate claims.	258	Days/units for procedure/revenue code.		
00513	Inpatient Respite Care, Rc655 Not Allowed More Than 5 Consecutive Days. Split And Rebill All Subsequent Days Of Hospital Stay As Rc651 Routine Home Care	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N63	Rebill services on separate claim lines.	258	Days/units for procedure/revenue code.		
00514	Cap Limitation For Respite Care Has Been Exceeded	B5	Coverage/program guidelines were not met or were exceeded.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00514	Cap Limitation For Respite Care Has Been Exceeded	B5	Coverage/program guidelines were not met or were exceeded.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
00515	Service Included In Health Check Package	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00516	Claim Denied. Service Not In Accordance With Rehab Guidelines	B5	Coverage/program guidelines were not met or were exceeded.					21	Missing or invalid information.		
00519	Hepatitis B Surface Or Core Antibody Allowed Once Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M90	Not covered more than once in a 12 month period.	259	Frequency of service.		
00520	Lab Test Allowed Once Every 3 Months For Chronic Respiratory Disease	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00521	Supply Code Denied. Additional Payment Not Allowed Unless Facility-Based Procedure Has Been Performed In Physician Office	96	Non-covered charge(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M77	Missing/incomplete/invali d place of service.	258	Days/units for procedure/revenue code.		
00521	Supply Code Denied. Additional Payment Not Allowed Unless Facility-Based Procedure Has Been Performed In Physician Office	96	Non-covered charge(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	258	Days/units for procedure/revenue code.		
00527	Laboratory Services Included In Hospital Reimbursement	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00529	Rebill Assistant Surgeon On Separate Claim	125	Submission/billing error(s). 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.)			N93	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.	21	Missing or invalid information.		
00530	Services Included In Initial Dialysis Training Fee	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00531	Services Included In Monthly Professional Dialysis Fee	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00532	Only One Ekg Allowed In 3 Months For Dialysis Patients	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00533	Only One Nerve Velocity Test Allowed In 3 Months For Dialysis	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00534	Copay Previously Deducted For This Date Of Service	3	Co-payment Amount					104	Processed according to plan provisions (Plan refers to provisions that exist between the Health Plan and the Consumer or Patient)		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00535	Maximum Allowable Facility Fee Has Been Reached	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)					483	Maximum coverage amount met or exceeded for benefit period.		
00536	Total Surgical Time Must Be Indicated On 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.			M53	Missing/incomplete/invalid days or units of service.	21	Missing or invalid information.		
00537	Procedure Code Or Procedure/Modifier Code Combination Is Not Covered For This Date Of Service	96	Non-covered charge(s). 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.) 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.	453	Procedure Code Modifier(s) for Service(s) Rendered		
00537	Procedure Code Or Procedure/Modifier Code Combination Is Not Covered For This Date Of Service	96	Non-covered charge(s). 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.) 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.	457	Non-Covered Day(s)		
00544	Chemotherapy Administration Denied. Office Visit Or Consult Included In Administration Fee Previously Paid To The Same Provider For This Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00545	Pdn Services Are Non-Covered When Recipient Is Receiving Inpatient Services	96	Non-covered charge(s). 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.) 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.		
00546	Chemo Administration Code Includes Surgical Procedure Previously Paid To Same Provider For Same Date Of Service. Refund Or Request Recoupment Of Paid Surgery Code For Reconsideration Of Chemo Administration 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.		
00551	Esrd Related Services Allowed Once Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00552	Therapeutic Radiology Port Films Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00552	Therapeutic Radiology Port Films Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00553	Timely Limit Exceeded. Resubmit As An Adjustment With Documentation Of Time	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	263	Length of time for services rendered.		
00553	Timely Limit Exceeded. Resubmit As An Adjustment With Documentation Of Time	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	294	Supporting documentation.		
00555	Daily And Monthly End Stage Renal Disease Related Services Not Allowed Within The Same Calendar Month	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00561	Acellular Dtp Vaccine Allowed Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00561	Acellular Dtp Vaccine Allowed Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00562	Service Is Included In The Chemotherapy Administration Code Previously Paid To The Same Provider For This Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00568	Depo-Provera 150 Mg For Contraceptive Use Limited To One Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00568	Depo-Provera 150 Mg For Contraceptive Use Limited To One Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00570	Percutaneous Transluminal Angioplasty Limit To Four Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00570	Percutaneous Transluminal Angioplasty Limit To Four Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00571	Percutaneous Transluminal Atherectomy Limited To Four Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00571	Percutaneous Transluminal Atherectomy Limited To Four Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00585	Claim Denied. Procedure Code Billed Is On The Medical Unncessary Event Table For The Ncci										
00586	Header Service End Date Is Outside Of Mce/Drg Date Range	A8	Ungroupable DRG.	CO	Contractual Obligations	N50	Missing/incomplete/invalid discharge information.	187	Date(s) of service.		
00591	Claims History Shows Medicaid Has Previously Paid For Tonsillectomies For This Recipient. Resubmit Corrected Claim Or File As An Adjustment With Operative Note And Path Report	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	298	Operative report.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00591	Claims History Shows Medicaid Has Previously Paid For Tonsillectomies For This Recipient. Resubmit Corrected Claim Or File As An Adjustment With Operative Note And Path Report	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	311	Pathology notes/report.		
00591	Claims History Shows Medicaid Has Previously Paid For Tonsillectomies For This Recipient. Resubmit Corrected Claim Or File As An Adjustment With Operative Note And Path Report	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	65	Claim/line has been paid.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00591	Claims History Shows Medicaid Has Previously Paid For Tonsillectomies For This Recipient. Resubmit Corrected Claim Or File As An Adjustment With Operative Note And Path Report	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M30	Missing pathology report.	298	Operative report.		
00591	Claims History Shows Medicaid Has Previously Paid For Tonsillectomies For This Recipient. Resubmit Corrected Claim Or File As An Adjustment With Operative Note And Path Report	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M30	Missing pathology report.	311	Pathology notes/report.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00591	Claims History Shows Medicaid Has Previously Paid For Tonsillectomies For This Recipient. Resubmit Corrected Claim Or File As An Adjustment With Operative Note And Path Report	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M30	Missing pathology report.	65	Claim/line has been paid.		
00592	Claims History Shows Medicaid Has Previously Paid For Adenoidectomies For This Recipient. Resubmit Corrected Claim Or File As An Adjustment With Operative Note And Path Report	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	298	Operative report.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00592	Claims History Shows Medicaid Has Previously Paid For Adenoidectomies For This Recipient. Resubmit Corrected Claim Or File As An Adjustment With Operative Note And Path Report	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	311	Pathology notes/report.		
00592	Claims History Shows Medicaid Has Previously Paid For Adenoidectomies For This Recipient. Resubmit Corrected Claim Or File As An Adjustment With Operative Note And Path Report	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	65	Claim/line has been paid.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00592	Claims History Shows Medicaid Has Previously Paid For Adenoidectomies For This Recipient. Resubmit Corrected Claim Or File As An Adjustment With Operative Note And Path Report	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M30	Missing pathology report.	298	Operative report.		
00592	Claims History Shows Medicaid Has Previously Paid For Adenoidectomies For This Recipient. Resubmit Corrected Claim Or File As An Adjustment With Operative Note And Path Report	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M30	Missing pathology report.	311	Pathology notes/report.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00592	Claims History Shows Medicaid Has Previously Paid For Adenoidectomies For This Recipient. Resubmit Corrected Claim Or File As An Adjustment With Operative Note And Path Report	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M30	Missing pathology report.	65	Claim/line has been paid.		
00594	Service Denied. Components Of This Blood Panel Have Already Been Paid For The Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00595	Service Denied. 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.		
00596	Billed Procedure Limited To One Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00596	Billed Procedure Limited To One Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00600	Allow One Full Mouth Debridement To Enable Comprehensive Periodontal Evaluation And Diagnosis Every 364 Days	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00601	Only Four Quadrants Of Periodontal Surgery Allowed Per Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00601	Only Four Quadrants Of Periodontal Surgery Allowed Per Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
00603	Allow One Oral Evaluation Within 6 Calendar Months	119	Benefit maximum for this time period or occurrence has been reached.			N59	Please refer to your provider manual for additional program and provider information.	259	Frequency of service.		
00603	Allow One Oral Evaluation Within 6 Calendar Months	119	Benefit maximum for this time period or occurrence has been reached.			N59	Please refer to your provider manual for additional program and provider information.	483	Maximum coverage amount met or exceeded for benefit period.		
00604	Maximum Daily Units Exceeded For Service. Limit For Service Is 8 Units Per Day (1 Unit = 1 Hour). Correct And Resubmit As A New Claim	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
00604	Maximum Daily Units Exceeded For Service. Limit For Service Is 8 Units Per Day (1 Unit = 1 Hour). Correct And Resubmit As A New Claim	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
00605	Allow One Routine Dental Prophylaxis Within 6 Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N59	Please refer to your provider manual for additional program and provider information.	259	Frequency of service.		
00605	Allow One Routine Dental Prophylaxis Within 6 Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N59	Please refer to your provider manual for additional program and provider information.	483	Maximum coverage amount met or exceeded for benefit period.		
00606	Two Periodontal Maintenance Procedures Allowed Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00608	Recommended Immunization Schedule Exceeded For This Vaccine. Recipient Has Received Same Immunization Within 300 Days Of Claim Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00610	Tooth Number Missing Or Invalid. Correct Detail And Resubmit Claim	125	Submission/billing error(s). 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.)			N37	Missing/incomplete/invalid tooth number/letter.	21	Missing or invalid information.		
00610	Tooth Number Missing Or Invalid. Correct Detail And Resubmit Claim	125	Submission/billing error(s). 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.)			N37	Missing/incomplete/invalid tooth number/letter.	242	Tooth numbers, surfaces, and/or quadrants involved.		
00612	Critical Care, First Hour Already Paid For This Date. Rebill Additional Time Using Cpt 99292	125	Submission/billing error(s). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	454	Procedure code for services rendered.		
00612	Critical Care, First Hour Already Paid For This Date. Rebill Additional Time Using Cpt 99292	125	Submission/billing error(s). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	54	Duplicate of a previously processed claim/line.		
00613	Ob Ultrasound 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.		
00613	Ob Ultrasound 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.	612	Per Day Limit Amount		
00614	Panorex Film Allowed Only Once Every Five Years Per State Limit	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00615	Extraction And Root Recovery Allowed Only Once Per Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			N117	This service is paid only once in a patient→s lifetime.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00617	Insertion Or Reinsertion Of Implantable Contraceptive Capsules (Norplant) Is Allowed Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00617	Insertion Or Reinsertion Of Implantable Contraceptive Capsules (Norplant) Is Allowed Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00618	Removal Of Implantable Contraceptive Capsule (Norplant) Is Allowed Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00618	Removal Of Implantable Contraceptive Capsule (Norplant) Is Allowed Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00619	Verify Source Of Prior Payment. If Filing For Additional Payment From Medicaid, Submit Through Adjustment Or Replacement Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.	1P	PROVIDER
00619	Verify Source Of Prior Payment. If Filing For Additional Payment From Medicaid, Submit Through Adjustment Or Replacement Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	25	Entity not approved.	1P	PROVIDER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00624	Duplicate Procedure. Service Already Paid For A Different Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00625	Allow Full Mouth Survey Once Every Five Years Per State Limit	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00626	Exceeds Maximum Allowed For Intraoral Films	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00626	Exceeds Maximum Allowed For Intraoral Films	119	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.		
00627	Only One Periapical Single First Film 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.		
00627	Only One Periapical Single First Film 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		
00631	Critical Care Previously Paid For This Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00633	Only 2 Prosthetic Lens Procedures Allowed Without Prior Approval	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
00635	One Venipuncture For Specimen Collection Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00635	One Venipuncture For Specimen Collection Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00636	One Catheterization For Collection Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00636	One Catheterization For Collection Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00637	One Cataract Surgery Procedure Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00637	One Cataract Surgery Procedure Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00645	Only 5 Hrs Of Psych/Cns/Neuro-Cognitive/Mental/Speech Testing Allowed Per Day. One Unit=1 Hr. If Billing More Than 5 Hrs Submit Adjustment Request With Documentation Of Time	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.			M53	Missing/incomplete/invalid days or units of service.	259	Frequency of service.		
00645	Only 5 Hrs Of Psych/Cns/Neuro-Cognitive/Mental/Speech Testing Allowed Per Day. One Unit=1 Hr. If Billing More Than 5 Hrs Submit Adjustment Request With Documentation Of Time	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.			M53	Missing/incomplete/invalid days or units of service.	263	Length of time for services rendered.		
00645	Only 5 Hrs Of Psych/Cns/Neuro-Cognitive/Mental/Speech Testing Allowed Per Day. One Unit=1 Hr. If Billing More Than 5 Hrs Submit Adjustment Request With Documentation Of Time	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.			M53	Missing/incomplete/invalid days or units of service.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00645	Only 5 Hrs Of Psych/Cns/Neuro-Cognitive/Mental/Speech Testing Allowed Per Day. One Unit=1 Hr. If Billing More Than 5 Hrs Submit Adjustment Request With Documentation Of Time	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.			N29	Missing documentation/orders/notes/summary/report/chart.	259	Frequency of service.		
00645	Only 5 Hrs Of Psych/Cns/Neuro-Cognitive/Mental/Speech Testing Allowed Per Day. One Unit=1 Hr. If Billing More Than 5 Hrs Submit Adjustment Request With Documentation Of Time	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.			N29	Missing documentation/orders/notes/summary/report/chart.	263	Length of time for services rendered.		
00645	Only 5 Hrs Of Psych/Cns/Neuro-Cognitive/Mental/Speech Testing Allowed Per Day. One Unit=1 Hr. If Billing More Than 5 Hrs Submit Adjustment Request With Documentation Of Time	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.			N29	Missing documentation/orders/notes/summary/report/chart.	612	Per Day Limit Amount		
00646	Tympanostomy Includes Myringotomy Procedure Previously Paid. Resubmit As An Adjustment	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00647	Myringotomy Included In Tympanostomy Code 69436 Previously Paid	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00648	Procedure Allowed Once Per Lifetime Without Prior Approval	149	Lifetime benefit maximum has been reached for this service/benefit category.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
00649	Ventilation Assist Management Includes Cpap And/Or Cnp Which Has Previously Been Paid	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00650	Cpap/Cnp Included In Ventilation Assist Management Already Paid	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00651	Repair/Replacement Of Pacemaker Previously Paid For This Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00652	Services Included In Pacemaker Insertion Previously Paid On This Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	54	Duplicate of a previously processed claim/line.		
00653	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.		
00654	Temporary Closure Of Eyelids By Suture Included In Fee For Eye Surgery Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00655	Only One Health Check Screening Or Interperiodic Screen Allowed Per Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00655	Only One Health Check Screening Or Interperiodic Screen Allowed Per Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00656	Only One Electroencephalogram Allowed Per Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
00656	Only One Electroencephalogram Allowed Per Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00658	Initial Supply Of Batteries Included In Dispensing Fee For New Hearing Aid/Aids	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00659	Home Infusion Therapy Self Administered Drugs Not Allowed Same Day As Private Duty Nursing	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00660	Iv-Pole Not Allowed Same Day As Hit Self Administered Drugs	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00665	Influenza And Pneumococcal Vaccines For Recipients 21 Years And Older Must Be Billed With The Appropriate Diagnosis	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	254	Primary diagnosis code. This change effective 11/1/2011: Principal doagnosis code.		
00665	Influenza And Pneumococcal Vaccines For Recipients 21 Years And Older Must Be Billed With The Appropriate Diagnosis	125	Submission/billing error(s). 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.)			N59	Please refer to your provider manual for additional program and provider information.	254	Primary diagnosis code. This change effective 11/1/2011: Principal doagnosis code.		
00667	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 patient→s lifetime.	259	Frequency of service.		
00678	Medicaid Does Not Reimburse For Multiple Repeat Sterilizations	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		
00679	Verify Diagnosis And Procedure(S) And Rebill With Federal Statement And Records If The Statement/Records Have Not Been Previously Submitted	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.		
00679	Verify Diagnosis And Procedure(S) And Rebill With Federal Statement And Records If The Statement/Records Have Not Been Previously Submitted	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.		
00679	Verify Diagnosis And Procedure(S) And Rebill With Federal Statement And Records If The Statement/Records Have Not Been Previously Submitted	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.		
00679	Verify Diagnosis And Procedure(S) And Rebill With Federal Statement And Records If The Statement/Records Have Not Been Previously Submitted	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00679	Verify Diagnosis And Procedure(S) And Rebill With Federal Statement And Records If The Statement/Records Have Not Been Previously Submitted	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.		
00679	Verify Diagnosis And Procedure(S) And Rebill With Federal Statement And Records If The Statement/Records Have Not Been Previously Submitted	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.		
00679	Verify Diagnosis And Procedure(S) And Rebill With Federal Statement And Records If The Statement/Records Have Not Been Previously Submitted	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	Please refer to your provider manual for additional program and provider information.	277	Paper claim.		
00679	Verify Diagnosis And Procedure(S) And Rebill With Federal Statement And Records If The Statement/Records Have Not Been Previously Submitted	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	Please refer to your provider manual for additional program and provider information.	294	Supporting documentation.		
00679	Verify Diagnosis And Procedure(S) And Rebill With Federal Statement And Records If The Statement/Records Have Not Been Previously Submitted	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	Please refer to your provider manual for additional program and provider information.	488	Diagnosis code(s) for the services rendered.		
00680	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.		
00680	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.		
00682	Induced Abortion Procedure Code Must Be Billed With Appropriate Diagnosis Code Correct And Resubmit	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M76	Missing/incomplete/invalid diagnosis or condition.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00682	Induced Abortion Procedure Code Must Be Billed With Appropriate Diagnosis Code Correct And Resubmit	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M76	Missing/incomplete/invalid diagnosis or condition.	277	Paper claim.		
00682	Induced Abortion Procedure Code Must Be Billed With Appropriate Diagnosis Code Correct And Resubmit	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M76	Missing/incomplete/invalid diagnosis or condition.	294	Supporting documentation.		
00682	Induced Abortion Procedure Code Must Be Billed With Appropriate Diagnosis Code Correct And Resubmit	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	21	Missing or invalid information.		
00682	Induced Abortion Procedure Code Must Be Billed With Appropriate Diagnosis Code Correct And Resubmit	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	277	Paper claim.		
00682	Induced Abortion Procedure Code Must Be Billed With Appropriate Diagnosis Code Correct And Resubmit	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	294	Supporting documentation.		
00686	Prior Approval Is Required For More Than 15 Consecutive Therapeutic Leave Days	197	Precertification/authorization/notification absent.			N54	Claim information is inconsistent with pre-certified/authorized services.	48	Referral/authorization.		
00686	Prior Approval Is Required For More Than 15 Consecutive Therapeutic Leave Days	197	Precertification/authorization/notification absent.			N54	Claim information is inconsistent with pre-certified/authorized services.	84	Service not authorized.		
00690	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 provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)		
00690	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00693	Only One Inpatient Respite 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.	259	Frequency of service.		
00693	Only One Inpatient Respite 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		
00694	Exceeds Daily Limit For Continuous Home Care, Rebill Using Rc651	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00694	Exceeds Daily Limit For Continuous Home Care, Rebill Using Rc651	119	Benefit maximum 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		
00695	Only One Colectomy Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00695	Only One Colectomy Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00696	Only One Colonoscopy Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00696	Only One Colonoscopy Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00698	One Unit Equals Multiple Determinations, Resubmit Billing Only One Unit	125	Submission/billing error(s). 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.)			M53	Missing/incomplete/invalid days or units of service.	259	Frequency of service.		
00698	One Unit Equals Multiple Determinations, Resubmit Billing Only One Unit	125	Submission/billing error(s). 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.)			M53	Missing/incomplete/invalid days or units of service.	476	Missing or invalid units of service		
00700	Use Established Office Visit Code	125	Submission/billing error(s). 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.)			M13	Only one initial visit is covered per specialty per medical group.	21	Missing or invalid information.		
00700	Use Established Office Visit Code	125	Submission/billing error(s). 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.)			M13	Only one initial visit is covered per specialty per medical group.	454	Procedure code for services rendered.		
00701	Second Surgery Reduced 50% If Performed On The Same Day	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					259	Frequency of service.		
00701	Second Surgery Reduced 50% If Performed On The Same Day	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					453	Procedure Code Modifier(s) for Service(s) Rendered		
00702	Periodic Orthodontic Treatment Visit (As Part Of Contract) Allowed Once 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.		
00705	Exceeds Limitation Per Dme Guidelines	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00708	Admission History And Physical Allowed Once Per Hospitalization. Transfers Within The Same Facility Do Not Support The Billing Of Admission. Rebill Appropriate Level Cpt E/M Code	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00709	Exceeds Once Per Month Limitation For Transcutaneous Electrical Nerve Stimulation (Tens) Procedure	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00710	Only One Corneal Transplant Per Day If Surgery Is Performed On Both Eyes. Document And Resubmit As 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.		
00710	Only One Corneal Transplant Per Day If Surgery Is Performed On Both Eyes. Document And Resubmit As 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		
00711	Only One Epidural Follow-Up Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00711	Only One Epidural Follow-Up Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00715	Orginal Surgery Fee Includes Multiple Stage Retinal Repair	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00716	Exceeds One Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00716	Exceeds One Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00720	Sterilization Under Both General Anesthesia And Epidural Anesthesia Not Allowed On The Same Day. Please File An Adjustment Request With Documentation For Exceptions	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	258	Days/units for procedure/revenue code.		
00720	Sterilization Under Both General Anesthesia And Epidural Anesthesia Not Allowed On The Same Day. Please File An Adjustment Request With Documentation For Exceptions	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00720	Sterilization Under Both General Anesthesia And Epidural Anesthesia Not Allowed On The Same Day. Please File An Adjustment Request With Documentation For Exceptions	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N29	Missing documentation/orders/notes/summary/report/chart.	258	Days/units for procedure/revenue code.		
00722	Each Additional Lesion Only Allowed When Billed On The Same Day As Preoperative Placement Needle Localization Wire; Breast	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		
00722	Each Additional Lesion Only Allowed When Billed On The Same Day As Preoperative Placement Needle Localization Wire; Breast	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00726	Cap Home Mobility Dollar Limitation Has Been Met	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)					483	Maximum coverage amount met or exceeded for benefit period.		
00730	Dental Exam Not Allowed On The Same Date Of Service As Limited Oral Evaluation-Problem Focused	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00732	Gamma Globulin May Be Billed Only One Time Per Date Of Service. If Billing Multiple Units Rebill Using The Appropriate Dose Specific Hcpc Code	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00732	Gamma Globulin May Be Billed Only One Time Per Date Of Service. If Billing Multiple Units Rebill Using The Appropriate Dose Specific Hcpc Code	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00739	Hiv Case Management Daily Limit Has Exceeded The Maximum Of 96 Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00739	Hiv Case Management Daily Limit Has Exceeded The Maximum Of 96 Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00739	Hiv Case Management Daily Limit Has Exceeded The Maximum Of 96 Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00739	Hiv Case Management Daily Limit Has Exceeded The Maximum Of 96 Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
00740	Cap Limitation Has Been Exceeded	B5	Coverage/program guidelines were not met or were exceeded.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
00740	Cap Limitation Has Been Exceeded	B5	Coverage/program guidelines were not met or were exceeded.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
00741	Multiple Surgery For Ambulatory Surgical Centers Cutback	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					259	Frequency of service.		
00741	Multiple Surgery For Ambulatory Surgical Centers Cutback	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					453	Procedure Code Modifier(s) for Service(s) Rendered		
00743	Eye Surgery Only Allowed Once Per Year For Each Eye	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.		
00749	Prior Claim For Case Management Has Been Paid For This Month	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00750	Therapeutic Leave Days Have Exceeded The Maximum Of 60 Allowed For The Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00752	Only Two Established Eye Exams Allowed Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00753	Claim Denied. Second Billing Of The Same Quadrant For Periodontal Scaling And Root Planing In 364 Days	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00754	Only 4 Quadrants Of Periodontal Scaling And Root Planing Allowed Every 364 Days	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00756	Only One Circumcision Allowed Per Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			N117	This service is paid only once in a patient→s lifetime.	259	Frequency of service.		
00757	Only 1 Therapeutic Apheresis 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.		
00757	Only 1 Therapeutic Apheresis 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		
00758	Only 1 Dental Sealant Allowed Per Tooth	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		
00759	Colposcopy Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00759	Colposcopy Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00761	Ophthalmoscopy Angiographies Allowed Six Times Every 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00762	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. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N180	This item or service does not meet the criteria for the category under which it was billed.	287	Medical necessity for service.		
00763	Cephalometric X-Ray And/Or Diagnostic Models Are Allowed Once In A Lifetime In Conjunction With An Initial Orthodontic Workup	149	Lifetime benefit maximum has been reached for this service/benefit category.			N117	This service is paid only once in a patient→s lifetime.	259	Frequency of service.		
00764	Comprehensive Orthodontic Treatment Of The Adolescent Dentition (Banding) Allowed Once Per Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			N117	This service is paid only once in a patient→s lifetime.	259	Frequency of service.		
00766	Medical Necessity For Multiple Non Stress Test Not Apparent	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N180	This item or service does not meet the criteria for the category under which it was billed.	278	Signed claim form.		
00768	Hearing Aid Batteries Allowed Six Times Per 365 Days	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00770	Limit Exceeded For Periodic Orthodontic Treatment Visits	119	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.		
00771	Procedure Allowed Once In A Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			N117	This service is paid only once in a patient→s lifetime.	259	Frequency of service.		
00773	Exceeds Limit 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.		
00775	Rc590 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00775	Rc590 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		
00779	Refractive Code Denied Due To A Medical Diagnosis Or Medical Office Visit Paid In History With The Same Date Of Service. If Necessary File An Adjustment To Correct The Diagnosis And Or Procedure Code	125	Submission/billing error(s). 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.)			M13	Only one initial visit is covered per specialty per medical group.	21	Missing or invalid information.		
00779	Refractive Code Denied Due To A Medical Diagnosis Or Medical Office Visit Paid In History With The Same Date Of Service. If Necessary File An Adjustment To Correct The Diagnosis And Or Procedure Code	125	Submission/billing error(s). 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.)			M13	Only one initial visit is covered per specialty per medical group.	454	Procedure code for services rendered.		
00781	Only One Psychiatric Interview Allowed Per Six Months	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00782	Only One Psychiatric Visit Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00782	Only One Psychiatric Visit Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00783	Pap Test Only Allowed Once Per Year For The Same Provider Unless Diagnosis Or Symptoms Warrant Additional Tests	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.		
00784	Facility Retraining Fees Limited To 15 Per Recipient'S Life Time	149	Lifetime benefit maximum has been reached for this service/benefit category.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00786	Only Three Visual Field Exams Allowed Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00787	Lupron Depot Allowed 16 Units Per 365 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
00788	Only One Therapeutic Abortion Allowed Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00789	Spinal Orthotics Allowed Once In 18 Months	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00790	Only Three Inhalers With Spacers Allowed Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00796	Pentamidine Aerosol Therapy Limited To Once Every 4 Weeks	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00802	Allow 1 Capco Personal Emergency Response System Alert 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.		
00805	Rebill Using Periodic Oral Examination Code	125	Submission/billing error(s). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	21	Missing or invalid information.		
00805	Rebill Using Periodic Oral Examination Code	125	Submission/billing error(s). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	239	Dental information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00807	Medical Necessity For Multiple Fetal Cardiovascular Ultrasounds Not Apparent	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N180	This item or service does not meet the criteria for the category under which it was billed.	287	Medical necessity for service.		
00809	Only One Fetal Cardiovascular Ultrasound 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.		
00809	Only One Fetal Cardiovascular Ultrasound 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		
00817	Services Cannot Be Billed Spanning Multiple Calendar Months. Rebill With Dates Of Service Within One Month Only	125	Submission/billing error(s). 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.)			MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	187	Date(s) of service.		
00817	Services Cannot Be Billed Spanning Multiple Calendar Months. Rebill With Dates Of Service Within One Month Only	125	Submission/billing error(s). 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.)			MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	21	Missing or invalid information.		
00817	Services Cannot Be Billed Spanning Multiple Calendar Months. Rebill With Dates Of Service Within One Month Only	125	Submission/billing error(s). 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.)			M53	Missing/incomplete/invalid days or units of service.	187	Date(s) of service.		
00817	Services Cannot Be Billed Spanning Multiple Calendar Months. Rebill With Dates Of Service Within One Month Only	125	Submission/billing error(s). 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.)			M53	Missing/incomplete/invalid days or units of service.	21	Missing or invalid information.		
00831	Dme Procedure Allowed Once In Two Years	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00832	Dme Equipment Allowed Once In Three Years. If Prior Approval Was Obtained For This Piece Of Equipment For Dates Of Service Prior To November 1, 1996, Please Resubmit As An Adjustment	119	Benefit maximum for this time period or occurrence has been reached.					187	Date(s) of service.		
00832	Dme Equipment Allowed Once In Three Years. If Prior Approval Was Obtained For This Piece Of Equipment For Dates Of Service Prior To November 1, 1996, Please Resubmit As An Adjustment	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		
00833	Dme Procedure Allowed Once In Five Years	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00835	Subsequent Billing Of Repair Code Has Been Paid At The Secondary Maximum Allowed Rate	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					259	Frequency of service.		
00835	Subsequent Billing Of Repair Code Has Been Paid At The Secondary Maximum Allowed Rate	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					453	Procedure Code Modifier(s) for Service(s) Rendered		
00840	Exceeds Daily Limit For At-Risk Case Management (Adult)	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00840	Exceeds Daily Limit For At-Risk Case Management (Adult)	119	Benefit maximum 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		
00842	Dme Equipment Allowed Once In Three Years	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00843	Dme Equipment Allowed Once In Three Years	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00844	Dme Equipment Allowed Once In Three Years	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00845	Dme Equipment Allowed Once In Five Years	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00846	Dme Equipment Allowed Once In Two Years	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00848	Dme Equipment Allowed Once In Three Years	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00849	Payment Reduced To Equal New Purchase Price. Medicaid Has Previously Paid For This Equipment Code	108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.	186	Purchase and rental price of durable medical equipment.		
00850	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.		
00851	Dme Equipment Allowed Once In Three Years	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00852	Dme Equipment Allowed Once In Three Years	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00853	Dme Equipment Allowed Once In Three Years	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00854	Dme Equipment Allowed Once In Three Years	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00855	Dme Equipment Allowed Once In Three Years	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00858	Dme Equipment Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00858	Dme Equipment Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00859	Dme Equipment Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00859	Dme Equipment Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00861	Dme Equipment Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00861	Dme Equipment Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00862	Dme Equipment Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00862	Dme Equipment Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00870	Personal Care Services Not Allowed Same Day As Cap In-Home Aide Level Ii And In-Home Aide Level Iii	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N205	Information provided was illegible	258	Days/units for procedure/revenue code.		
00871	Cap In-Home Aide Level Ii And In-Home Aide Level Iii Not Allowed Same Day As Personal Care Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N205	Information provided was illegible	258	Days/units for procedure/revenue code.		
00872	I&D Included In Previously Paid Appendectomy	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00873	Catheterization Included In Dilation	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00874	Multiple Er Visits Not Allowed Same Date Of Service, Same Taxonomy Qualifier. File Adjustment If Visits Were Separate Occasion	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other 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.		
00878	Episiotomy Included In Vaginal Delivery	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00879	Physician Charge Denied Same Date Of Service As Facility Billing	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N205	Information provided was illegible	258	Days/units for procedure/revenue code.		
00881	Emg One Extremity Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00881	Emg One Extremity Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00882	Emg Two Extremities Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00882	Emg Two Extremities Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00883	Emg Three Extremities Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00883	Emg Three Extremities Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00884	Rebill Adjustment With Records Documenting Units	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.			M53	Missing/incomplete/invalid days or units of service.	21	Missing or invalid information.		
00884	Rebill Adjustment With Records Documenting Units	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	21	Missing or invalid information.		
00886	Exceeds Limit Of Six Units Per Day For Reflex Study	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00886	Exceeds Limit Of Six Units Per Day For Reflex Study	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00887	Dme Equipment Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00887	Dme Equipment Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00889	Medicare Covered Days Missing Or Invalid. Refile Claim With Medicare	148	Information from another provider was not provided or was insufficient/incomplete. 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.)			N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	21	Missing or invalid information.		
00889	Medicare Covered Days Missing Or Invalid. Refile Claim With Medicare	148	Information from another provider was not provided or was insufficient/incomplete. 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.)			N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	286	Other payer's Explanation of Benefits/payment information.		
00889	Medicare Covered Days Missing Or Invalid. Refile Claim With Medicare	148	Information from another provider was not provided or was insufficient/incomplete. 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.)			N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	456	Covered Day(s)		
00891	Self Administered Drugs Limited To Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00891	Self Administered Drugs Limited To Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00893	Medical Necessity Not Apparent For Critical Care/Prolonged Services And Consults On The Same Day	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N180	This item or service does not meet the criteria for the category under which it was billed.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00893	Medical Necessity Not Apparent For Critical Care/Prolonged Services And Consults On The Same Day	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N180	This item or service does not meet the criteria for the category under which it was billed.	287	Medical necessity for service.		
00895	Exceeds Daily Limit For Termination Allowance	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)					259	Frequency of service.		
00895	Exceeds Daily Limit For Termination Allowance	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)					612	Per Day Limit Amount		
00896	Additional Procedure, Same Date Of Service, Paid At 50 Percent Of Allowable Amount	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					259	Frequency of service.		
00896	Additional Procedure, Same Date Of Service, Paid At 50 Percent Of Allowable Amount	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00897	Tcd Included In Fee For Surgery	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00899	Units Cutback. Maximum Number Of Units Per Day Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
00899	Units Cutback. Maximum Number Of Units Per Day Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
00899	Units Cutback. Maximum Number Of Units Per Day Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
00901	No Adjustment Due	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)					104	Processed according to plan provisions (Plan refers to provisions that exist between the Health Plan and the Consumer or Patient)		
00905	Drug Not Covered Under Rebate Agreement	96	Non-covered charge(s). 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.) 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.		
00906	Cervical Braces Allowed Once In 18 Months	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00911	Denied. Cms Termination	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.					104	Processed according to plan provisions (Plan refers to provisions that exist between the Health Plan and the Consumer or Patient)		
00914	Dispensing Fees For Accessories Are Included In The Dispensing Fee For A New Aid/Aids	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00920	Clia Identification 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). 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.)			MA120	Missing/incomplete/invalid CLIA certification number.	142	Entity's license/certification number.	1P	PROVIDER
00920	Clia Identification 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). 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.)			MA120	Missing/incomplete/invalid CLIA certification number.	21	Missing or invalid information.	1P	PROVIDER
00920	Clia Identification 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). 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.)			MA120	Missing/incomplete/invalid CLIA certification number.	630	Referring CLIA Number	1P	PROVIDER
00921	Service Denied: The Dispensing Fee For Accessories That Is Included In Dispensing Fee For New Hearing Aid(S) Has Been Paid For This Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00923	Consultation And Emergency Room Visit Not Allowed On Same Dos, Same Provider Taxonomy Qualifier	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00924	Emergency Room Visit And Consultation Not Allowed On Same Dos, Same Provider Taxonomy Qualifier	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00925	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). 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.)			MA30	Missing/incomplete/invalid type of bill.	189	Facility admission date		
00925	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). 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.)			MA30	Missing/incomplete/invalid type of bill.	21	Missing or invalid information.		
00925	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). 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.)			MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	189	Facility admission date		
00925	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). 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.)			MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	21	Missing or invalid information.		
00928	Injection Of Antigen Is Included In The Fee For Allergenic Immunotherapy With Provision Of Allergenic Extract Already Paid For This Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00929	Injection Of Antigen Has Already Been Paid For This Date Of Service. Rebill Using Code For Provision Of Allergenic Extract Only	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
00930	Any Combination Of Periodontal And Prophylaxis Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00931	Patient Must Be Eligible On Banding Date And Banding Claim Must Be Paid To Allow Payment Of Periodic Orthodontic Treatment Visit	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.	QC	PATIENT
00933	J1055 Not Allowed On The Same Date Of Service As J1050 Or J1051	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00934	J1050 Or J1051 Is Not Allowed On The Same Date Of Service As J1055	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00936	Clia Cert Not Valid For Dos/Level. If You Have Only 1 Clia #, Contact Agency That Issued Certification. If Multi Clia #, Send Copy Of Cert/Claim & Inquiry Form To Csc Provider Services	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.			MA120	Missing/incomplete/invalid CLIA certification number.	142	Entity's license/certification number.	1P	PROVIDER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00936	Clia Cert Not Valid For Dos/Level. If You Have Only 1 Clia #, Contact Agency That Issued Certification. If Multi Clia #, Send Copy Of Cert/Claim & Inquiry Form To Csc Provider Services	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.			MA120	Missing/incomplete/invalid CLIA certification number.	21	Missing or invalid information.	1P	PROVIDER
00936	Clia Cert Not Valid For Dos/Level. If You Have Only 1 Clia #, Contact Agency That Issued Certification. If Multi Clia #, Send Copy Of Cert/Claim & Inquiry Form To Csc Provider Services	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.			MA120	Missing/incomplete/invalid CLIA certification number.	630	Referring CLIA Number	1P	PROVIDER
00941	Prescription Number Required	125	Submission/billing error(s). 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.)			M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	219	Prescription number.		
00944	Professional Variance/Quantity	154	Payer deems the information submitted does not support this day's supply.			M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	21	Missing or invalid information.		
00944	Professional Variance/Quantity	154	Payer deems the information submitted does not support this day's supply.			M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	221	Drug days supply and dosage.		
00944	Professional Variance/Quantity	154	Payer deems the information submitted does not support this day's supply.			M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	21	Missing or invalid information.		
00944	Professional Variance/Quantity	154	Payer deems the information submitted does not support this day's supply.			M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	221	Drug days supply and dosage.		
00952	Fixation Of Femar Fracture Included In Hemiarthroplasty, Hip Partial	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00953	Individual Has Restricted Coverage - Medicaid Only Pays The Part B Premium	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.					84	Service not authorized.		
00955	Fqhc ┬ Attending/Group Provider Number	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	562	Entity's National Provider Identifier (NPI).	71	ATTENDING PHYSICIAN
00956	Comprehensive Evaluation And Related Components Not Allowed On The Same Dos, Same Or Different Provider	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00957	Dialysis Treatment Allowed Once Per Day. If More Than One Treatment Is Provided Submit An Adjustment With Documentation Showing Medical Necessity	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00957	Dialysis Treatment Allowed Once Per Day. If More Than One Treatment Is Provided Submit An Adjustment With Documentation Showing Medical Necessity	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
00958	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.		
00958	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		
00959	Maximum Number Of Units Per Day Previously Paid For This Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00959	Maximum Number Of Units Per Day Previously Paid For This Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N20	Service not payable with other service rendered on the same date.	612	Per Day Limit Amount		
00961	Newborn Health Check Screen And Newborn Assessment Not Allowed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
00967	Dhs Immunizations Cannot Be Assigned A Family Planning Category Of Service; No Family Planning Cos Exists For Required Financial Treatment	150	Payer deems the information submitted does not support this level of service.			N180	This item or service does not meet the criteria for the category under which it was billed.	454	Procedure code for services rendered.		
00971	Periodontal Maintenance Procedures Are Allowed Only As Follow-Up To Periodontal Surgery	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
00971	Periodontal Maintenance Procedures Are Allowed Only As Follow-Up To Periodontal Surgery	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N188	The approved level of care does not match the procedure code submitted.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00972	Over 3 Hours Of Unusual Physician Travel Must Be Documented. Please Resubmit Claim With Records	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	263	Length of time for services rendered.		
00972	Over 3 Hours Of Unusual Physician Travel Must Be Documented. Please Resubmit Claim With Records	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	294	Supporting documentation.		
00983	Dispensing Fee Was Cut Back (Same Drug In The Same Month)	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
00993	Exceeds 4 Per 365 Day Limitation. Submit As An Adjustment Documenting The Medical Necessity For Additional Lens/Lense	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00993	Exceeds 4 Per 365 Day Limitation. Submit As An Adjustment Documenting The Medical Necessity For Additional Lens/Lense	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	287	Medical necessity for service.		
00993	Exceeds 4 Per 365 Day Limitation. Submit As An Adjustment Documenting The Medical Necessity For Additional Lens/Lense	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	294	Supporting documentation.		
00997	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 (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
00998	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). 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.)			N59	Please refer to your provider manual for additional program and provider information.	21	Missing or invalid information.		
01002	Exceeds Cap-Mr/Dd Personal Emergency Response Monthly Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01003	Date Of Service Is More Than 30 Days Prior To Cap Effective Date	177	Patient has not met the required eligibility requirements.			N30	Patient ineligible for this service.	91	Entity not eligible/not approved for dates of	QC	PATIENT
01004	Cap Services Recouped To Pay Inpatient Stay Charges. Cap Services Are Not Allowed During Inpatient Stay					M2	Not paid separately when the patient is an inpatient.	258	Days/units for procedure/revenue code.		
01004	Cap Services Recouped To Pay Inpatient Stay Charges. Cap Services Are Not Allowed During Inpatient Stay					N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01004	Cap Services Recouped To Pay Inpatient Stay Charges. Cap Services Are Not Allowed During Inpatient Stay					N30	Patient ineligible for this service.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01005	Cap Services Denied When Recipient Is Receiving Inpatient Services					M2	Not paid separately when the patient is an inpatient.	258	Days/units for procedure/revenue code.		
01005	Cap Services Denied When Recipient Is Receiving Inpatient Services					N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01005	Cap Services Denied When Recipient Is Receiving Inpatient Services					N30	Patient ineligible for this service.	258	Days/units for procedure/revenue		
01006	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.		
01009	Claim Denied. Procedure Included In Related Procedure Already Billed	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01013	Adult Care Home Personal Care Services Are Not Reimbursed When Therapeutic Leave Has Been Paid For The Same Date(S) Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01014	Service Denied Or Cut Back. Exceeds 14 Consecutive Day Limit	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
01014	Service Denied Or Cut Back. Exceeds 14 Consecutive Day Limit	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01017	Initial Observation Has Already Been Paid For This Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01018	Observation Discharge Has Already Been Paid For This Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01019	Evaluation And Management Not Allowed Same Day As Nicu. Nicu Has Already Been Paid For This Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
01020	Initial Hour Of Prolonged Services Allowed Once Per Date Of Service. Service Has Already Been Paid For This Date	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01020	Initial Hour Of Prolonged Services Allowed Once Per Date Of Service. Service Has Already Been Paid For This Date	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01021	Critical Care Not Allowed On Same Date Of Service As Prolonged Service. Prolonged Service Already Paid For This Date	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
01024	Prolonged Service Already Paid For This Date Of Service. No Additional Payment Allowed For Stand-By On Same Dos	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01026	Reimbursement For Related Procedure Is Being Recouped To Pay For Primary Procedure (52647 Or 52648)	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01027	Reimbursement For Therapeutic Leave Denied. Adult Care Home Pcs Has Been Paid For The Same Date(S) Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01028	Cap-Mr/Dd Supported Employment Services Not Allowed Same Day As Prevocational Services Or Institutional Respite Care	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01029	Cap-Mr/Dd Institutional Respite Not Allowed On Same Day As Related Cap Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01030	Personal Care And Adult Care Home Not Allowed On Same Day As Cap-Mr/Dd Supported Living Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01031	Cap-Mr/Dd Supported Living Services Not Allowed On Same Day As Personal Care And Adult Care Home	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01032	Cap-Mr/Dd Supported Living Not Allowed Same Day As Related Cap Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01033	Related Cap-Mr/Dd Services Not On Same Day As Supported Living Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01034	Cap-Mr/Dd Crisis Stabilization Not Allowed On Same Date Of Service As Institutional Respite Care	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01036	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.	IN	INSURER
01036	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	IN	INSURER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01040	Personal Care Services Not Allowed On Same Date Of Service As Adult Care Home Personal Care Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01042	Only One Case Management Allowed Per Day. Case Management Billed Through Another Program Has Already Been Paid For This Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01044	Multiple Billings Of Same Or Similar Dme Supply/Equipment Not Allowed On The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01051	At-Risk Case Management Not Allowed On Same Day As Related Case Management Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01053	At-Risk Case Management Services Are Noncovered When Recipient Is Receiving Inpatient Services					M2	Not paid separately when the patient is an inpatient.	258	Days/units for procedure/revenue code.		
01053	At-Risk Case Management Services Are Noncovered When Recipient Is Receiving Inpatient Services					N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01053	At-Risk Case Management Services Are Noncovered When Recipient Is Receiving Inpatient Services					N30	Patient ineligible for this service.	258	Days/units for procedure/revenue code.		
01054	At-Risk Case Management Service Recouped. This Service Not Allowed When Recipient Is Receiving Inpatient Services					M2	Not paid separately when the patient is an inpatient.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01054	At-Risk Case Management Service Recouped. This Service Not Allowed When Recipient Is Receiving Inpatient Services					N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01054	At-Risk Case Management Service Recouped. This Service Not Allowed When Recipient Is Receiving Inpatient Services					N30	Patient ineligible for this service.	258	Days/units for procedure/revenue code.		
01055	Er And Hospital Admission Not Allowed Same Dos/Same Provider	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M2	Not paid separately when the patient is an inpatient.	258	Days/units for procedure/revenue code.		
01055	Er And Hospital Admission Not Allowed Same Dos/Same Provider	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01055	Er And Hospital Admission Not Allowed Same Dos/Same Provider	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N30	Patient ineligible for this service.	258	Days/units for procedure/revenue code.		
01056	Er Services Recouped. Er Services And Hospital Admission Not Allowed Same Dos/Same Provider	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M2	Not paid separately when the patient is an inpatient.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01056	Er Services Recouped. Er Services And Hospital Admission Not Allowed Same Dos/Same Provider	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01056	Er Services Recouped. Er Services And Hospital Admission Not Allowed Same Dos/Same Provider	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N30	Patient ineligible for this service.	258	Days/units for procedure/revenue code.		
01057	Valid Revenue Code Must Be Billed With A Valid Hcpc Code. Hcpc Code Is Missing Or Invalid Or Hcpc Code Has Been Bille With Missing Or Invalid Revenue Code. Correct And Resubmit	125	Submission/billing error(s). 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.)			M20	Missing/incomplete/invalid HCPCS.	21	Missing or invalid information.		
01057	Valid Revenue Code Must Be Billed With A Valid Hcpc Code. Hcpc Code Is Missing Or Invalid Or Hcpc Code Has Been Bille With Missing Or Invalid Revenue Code. Correct And Resubmit	125	Submission/billing error(s). 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.)			M20	Missing/incomplete/invalid HCPCS.	455	Revenue code for services rendered.		
01057	Valid Revenue Code Must Be Billed With A Valid Hcpc Code. Hcpc Code Is Missing Or Invalid Or Hcpc Code Has Been Bille With Missing Or Invalid Revenue Code. Correct And Resubmit	125	Submission/billing error(s). 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.)			M50	Missing/incomplete/invalid revenue code(s).	21	Missing or invalid information.		
01057	Valid Revenue Code Must Be Billed With A Valid Hcpc Code. Hcpc Code Is Missing Or Invalid Or Hcpc Code Has Been Bille With Missing Or Invalid Revenue Code. Correct And Resubmit	125	Submission/billing error(s). 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.)			M50	Missing/incomplete/invalid revenue code(s).	455	Revenue code for services rendered.		
01058	The Only Well Child Exam Billable Through The Medicaid Program Is A Health Check Screen	125	Submission/billing error(s). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01060	Admit Hour/Time Of Pickup Is Missing Or Invalid. Please Correct And Resubmit As A New Claim	125	Submission/billing error(s). 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.)			N46	Missing/incomplete/invalid admission hour.	21	Missing or invalid information.		
01061	Only One Date Of Service Allowed Per Claim. Bill Each Ambulance Trip On A Separate Claim	125	Submission/billing error(s). 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.)			M53	Missing/incomplete/invalid days or units of service.	258	Days/units for procedure/revenue code.		
01066	Cap In-Home Aide Service Not Allowed On Same Date Of Service As Adult Care Homes 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.		
01067	Home Health Aide Service Not Allowed On Same Date Of Service As Adult Care Home Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01068	Component(S) Of Urinalysis Recouped. Urinalysis With Micro Scopy-(Complete Service), Has Been Paid For This Date Of Service, Same Billing Provider	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01069	Component(S) Denied. Urinalysis With Microscopy-(Complete Procedure) Has Already Been Paid For This Date Of Service, Same Billing Provider	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01070	Urinalysis Components Billed For The Same Date Of Service Must Be Combined Under 81000. Please Submit Adjustment For Component(S) Already Paid	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01070	Urinalysis Components Billed For The Same Date Of Service Must Be Combined Under 81000. Please Submit Adjustment For Component(S) Already Paid	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	454	Procedure code for services rendered.		
01071	Urinalysis Components Billed For The Same Date Of Service Must Be Combined Under 81000. Please Submit Adjustment For Component(S) Already Paid	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01071	Urinalysis Components Billed For The Same Date Of Service Must Be Combined Under 81000. Please Submit Adjustment For Component(S) Already Paid	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	454	Procedure code for services rendered.		
01072	Renin Stimulation Panel Has Been Paid For This Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01074	Components Of Audiometry/Speech Recognition Recouped. The Complete Service - Comprehensive Audiometry Evaluation And Speech Recognition Has Already Been Paid This Day, Same Billing Provider	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01075	Component(S) Denied. Comprehensive Audiometry And Speech Recognition, Which Is A Complete Procedure, Has Already Bee Paid For This Date Of Service, Same Billing Provider	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01076	Audiometry Components Billed For The Same Date Of Service Must Be Combined As 92557. Please Submit An Adjustment For Component 92556 That Already Paid	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01077	Audiometry Components Billed For The Same Date Of Service Must Be Combined As 92557. Please Submit An Adjustment For Component 92553 That Already Paid	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01079	Detail Transportation Days Cannot Exceed Total Header Days For Domiciliary Care	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.			M52	Missing/incomplete/invali d →from→ date(s) of service.	258	Days/units for procedure/revenue code.		
01079	Detail Transportation Days Cannot Exceed Total Header Days For Domiciliary Care	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.			M52	Missing/incomplete/invali d →from→ date(s) of service.	476	Missing or invalid units of service		
01079	Detail Transportation Days Cannot Exceed Total Header Days For Domiciliary Care	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.			M59	Missing/incomplete/invali d →to→ date(s) of service.	258	Days/units for procedure/revenue code.		
01079	Detail Transportation Days Cannot Exceed Total Header Days For Domiciliary Care	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.			M59	Missing/incomplete/invali d →to→ date(s) of service.	476	Missing or invalid units of service		
01080	Procedure Billed Exceeds One Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01083	Only One Spine Deformity Arthrodesis Can Be Billed Per Operative Episode, Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01084	Conflict In Procedures Billed. Anterior & Posterior Procedures Billed For Same Date Of Service. Review, Correct, And Resubmit Or File An Adjustment With Records	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	21	Missing or invalid information.		
01084	Conflict In Procedures Billed. Anterior & Posterior Procedures Billed For Same Date Of Service. Review, Correct, And Resubmit Or File An Adjustment With Records	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	294	Supporting documentation.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01086	Review Procedures Billed. Only One Instrumentation Procedure Allowed Per Day.Correct And Resubmit As A New Claim	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01088	Cap-Mr/Dd Adult Day Health Or Developmental Day Care Not Allowed On Same Day As Institutional Respite	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01089	Cap-Mr/Dd Personal Care Service Not Allowed On Same Day As Institutional Respite	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01093	Claim Denied. Antepartum Package 59425 Has Already Been Paid For This Gestation Period	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01094	Stand-By Service Already Paid For This Date Of Service. No Additional Payment Allowed For Prolonged Service On Same Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01095	Observation Service Already Paid For This Date Of Service. No Additional Payment Allowed For Prolonged Service Same Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01096	Nicu Already Paid For This Date Of Service. No Additional Payment Allowed For Prolonged Service 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01097	Critical Care Has Already Paid For This Date Of Service. No Additional Payment Allowed For Prolonged Service 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.		
01098	Antepartum Package Has Already Been Paid For This Gestation Period	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01099	Nicu Not Allowed Same Day As Evaluation And Management Code. E/M Already Paid For This Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01102	Initial Viewing Of The X-Ray By The Er Physician Is Included In The Er Visit And Will Not Be Reimbursed Serarately	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 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.		
01103	Qty Outside Of Min And Max Limits	119	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.		
01104	Unacceptable Price/Unit. Check Quantity And Price	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.			M51	Missing/incomplete/invalid procedure code(s).	21	Missing or invalid information.		
01104	Unacceptable Price/Unit. Check Quantity And Price	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.			M53	Missing/incomplete/invalid days or units of service.	21	Missing or invalid information.		
01105	Partial Dispensing Of Unbreakable Pack	B5	Coverage/program guidelines were not met or were exceeded.					107	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01106	Exceeds Limit Of Billings For Antepartum Package 4-6 Visits By Different Providers	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		
01112	Related Services Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01123	Pos - Metric Decimal Quantity Missing Or Invalid	B5	Coverage/program guidelines were not met or were exceeded.					21	Missing or invalid information.		
01124	Pos - Dur Alert Override Not Found	B5	Coverage/program guidelines were not met or were exceeded.					21	Missing or invalid information.		
01140	Component Of X-Ray (Either Technical Or Professional) Denied. Same Procedure Code Has Already Been Reimbursed As Complete Procedure For This Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01141	X-Ray Billed As 'Complete' Denied. Technical Component Of This Procedure Code Has Already Been Reimbursed For This Date. Rebill For Professional Component Only	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01142	X-Ray Billed As 'Complete' Denied. Professional Component O This Procedure Code Has Already Been Reimbursed For This Date. Rebill For Technical Component Only	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N195	The technical component must be billed separately.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01142	X-Ray Billed As 'Complete' Denied. Professional Component O This Procedure Code Has Already Been Reimbursed For This Date. Rebill For Technical Component Only	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01147	Cystourethroscopy With Meatotomy Not Allowed On Same Day As Cysto. With Resection. Resubmit As An Adjustment With Documentation Supporting Second Cystourethroscopy On Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	258	Days/units for procedure/revenue code.		
01147	Cystourethroscopy With Meatotomy Not Allowed On Same Day As Cysto. With Resection. Resubmit As An Adjustment With Documentation Supporting Second Cystourethroscopy On Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01148	Cystourethroscopy With Resection Of Ureterocele Paid. Cysto With Meatotomy Recouped. Resubmit As An Adjustment With Documentation Supporting Second Cystourethroscopy On Same Day	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01151	Probing Of Nasolacrimal Duct With Or Without Irrigation Is Included In A More Comprehensive Procedure Already Paid	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01152	Components Denied. Rebill Using 92557 As Complete Procedure Versus Separate Components 92553 And 92556	125	Submission/billing error(s). 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.)			N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01153	Comprehensive Procedure For Probing Nasolacrimal Duct, Which Includes Irrigation Paid. Separate Payment For Component Of Comprehensive Procedure Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01154	Claim Denied Pending Rate Information From Dma	133	The disposition of the claim/service is pending further review. (Use only with Group Code OA)					3	Claim has been adjudicated and is awaiting payment cycle.		
01157	Delivery And/Or Postpartum Care Included In Total Ob Package	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01158	Antepartum Package Recouped. Total Ob Package Paid Which Includes Antepartum Care	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01159	Total Ob Package, Which Includes Antepartum Care, Has Already Been Paid For This Gestation Period	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01162	Postpartum Package Recouped. Total Ob Package Paid Includes Postpartum Care	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01163	Total Ob Package, Which Includes Postpartum Care, Has Already Been Paid For This Gestation Period	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01164	Transposition Of Ovaries Included In Abdominal Hysterectomy. Resubmit As An Adjustment With Records If Ovaries Were Not Returned To Original Placement	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	294	Supporting documentation.		
01164	Transposition Of Ovaries Included In Abdominal Hysterectomy. Resubmit As An Adjustment With Records If Ovaries Were Not Returned To Original Placement	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	297	Medical notes/report.		
01164	Transposition Of Ovaries Included In Abdominal Hysterectomy. Resubmit As An Adjustment With Records If Ovaries Were Not Returned To Original Placement	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	294	Supporting documentation.		
01164	Transposition Of Ovaries Included In Abdominal Hysterectomy. Resubmit As An Adjustment With Records If Ovaries Were Not Returned To Original Placement	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	297	Medical notes/report.		
01165	Abdominal Hysterectomy Includes The Transposition Of Ovaries. Resubmit As An Adjustment With Records If Ovaries Were Not Returned To Original Placement	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	294	Supporting documentation.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01165	Abdominal Hysterectomy Includes The Transposition Of Ovaries. Resubmit As An Adjustment With Records If Ovaries Were Not Returned To Original Placement	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	297	Medical notes/report.		
01165	Abdominal Hysterectomy Includes The Transposition Of Ovaries. Resubmit As An Adjustment With Records If Ovaries Were Not Returned To Original Placement	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	294	Supporting documentation.		
01165	Abdominal Hysterectomy Includes The Transposition Of Ovaries. Resubmit As An Adjustment With Records If Ovaries Were Not Returned To Original Placement	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	297	Medical notes/report.		
01166	Superficial Hyperthermia Recouped. Medicaid Does Not Make Separate Payment For Procedures That Are Components Of A More Comprehensive Service For The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01167	Dme Allowed Once In Four Years. Resubmit As An Adjustment If Prior Approval Was Obtained For This Piece Of Equipment For Dates Of Service Prior To November 1,1996	119	Benefit maximum for this time period or occurrence has been reached.					187	Date(s) of service.		
01167	Dme Allowed Once In Four Years. Resubmit As An Adjustment If Prior Approval Was Obtained For This Piece Of Equipment For Dates Of Service Prior To November 1,1996	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01168	Arthrodesis, Hip Joint Included In Fusion Of Hip Joint	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01169	Superficial Hyperthermia Denied. Medicaid Does Not Make Separate Payment For Procedures That Are Components Of A More Comprehensive Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01170	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). 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.)			M53	Missing/incomplete/invalid days or units of service.	258	Days/units for procedure/revenue code.		
01170	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). 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.)			M53	Missing/incomplete/invalid days or units of service.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01171	Diagnosis Requires Supporting Documentation. Resubmit As A Adjustment With Medical Records	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N163	Medical record does not support code billed per the code definition.	297	Medical notes/report.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01171	Diagnosis Requires Supporting Documentation. Resubmit As A Adjustment With Medical Records	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	297	Medical notes/report.		
01172	Tenotomy For Multiple Tendons Can Not Be Billed Same Date Of Service As Single Tendons	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01173	Claim Denied. Superficial Hyperthermia Not Allowed On Same Date Of Service As Chemotherapy Administration	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01174	Thanks For Reporting Vaccine To Our Database. This Vaccine Is Available At No Charge Through The Vaccines For Children Program And Therefore Is Not Reimbursable Through Medicaid	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.	IN	INSURER
01174	Thanks For Reporting Vaccine To Our Database. This Vaccine Is Available At No Charge Through The Vaccines For Children Program And Therefore Is Not Reimbursable Through Medicaid	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	IN	INSURER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01175	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). 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.)			M51	Missing/incomplete/invalid procedure code(s).	21	Missing or invalid information.		
01175	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). 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.)			M51	Missing/incomplete/invalid procedure code(s).	455	Revenue code for services rendered.		
01175	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). 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.)			N50	Missing/incomplete/invalid discharge information.	21	Missing or invalid information.		
01175	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). 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.)			N50	Missing/incomplete/invalid discharge information.	455	Revenue code for services rendered.		
01176	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.		
01177	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). 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.)			M51	Missing/incomplete/invalid procedure code(s).	21	Missing or invalid information.		
01177	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). 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.)			M51	Missing/incomplete/invalid procedure code(s).	455	Revenue code for services rendered.		
01177	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). 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.)			N50	Missing/incomplete/invalid discharge information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01177	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). 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.)			N50	Missing/incomplete/invalid discharge information.	455	Revenue code for services rendered.		
01179	Procedure Code 57505 Recouped. Endocervical Curettage Included In Procedure Code 57454	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01180	Endocervical Curettage Included In Previously Paid Procedure 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.		
01184	Insertion Of Vitrocert Is Covered Only For The Diagnosis Of Cytomegalovirus Retinitis (Cmv)	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.	255	Diagnosis code.		
01184	Insertion Of Vitrocert Is Covered Only For The Diagnosis Of Cytomegalovirus Retinitis (Cmv)	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	Please refer to your provider manual for additional program and provider information.	255	Diagnosis code.		
01185	Only One Billing Of Chiropractic Manipulative Treatment 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.		
01189	Medicaid Does Not Make Separate Payment For Professional Or Technical Component Performed On The Same Date Of Service As The Complete Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01190	Complete Procedure Performed On The Same Date Of Service As The Professional Or Technical Component Not Allowed. Component Recouped	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01191	Arthrotomy-Knee; With Sysnovial Biopsy Only Included In Joint Exploration, Bioplsy Or Removal	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01192	Medicaid Does Not Make Separate Payment For Professional Or Technical Component Performed On The Same Date Of Service As The Complete Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01193	Complete Procedure Performed On The Same Date Of Service As The Professional Or Technical Component Not Allowed. Component Recouped	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01194	Arthrotomy With Excision Of Semilunar Cartilage Included In Knee Excision Semilunar Cartilage	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01195	Medicaid Does Not Make Separate Payment For Professional Or Technical Component Performed On The Same Date Of Service As The Complete Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01196	Complete Procedure Performed On The Same Date Of Service As The Professional Or Technical Component Not Allowed. Component Recouped	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01197	Physician Services And Visual Aids Cannot Be Processed On The Same Claim. Resubmit Physician Services On A Separate Cms 1500 Claim	125	Submission/billing error(s). 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.)			N61	Rebill services on separate claims.	276	UB04/HCFA-1450/1500 claim form		
01197	Physician Services And Visual Aids Cannot Be Processed On The Same Claim. Resubmit Physician Services On A Separate Cms 1500 Claim	125	Submission/billing error(s). 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.)			N61	Rebill services on separate claims.	481	Claim/submission format is invalid.		
01199	Related Lab Tests Included In Fee For Panel, Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01200	Panel Includes Fees For Related Lab Tests, Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01201	Patient Is Enrolled In A Hmo Plan. Delivery Charges Have Been Made To 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.					187	Date(s) of service.	1E	HEALTH MAINTENANCE ORGANIZATION (HMO)
01201	Patient Is Enrolled In A Hmo Plan. Delivery Charges Have Been Made To 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.					585	Denied Charge or Non-covered Charge	1E	HEALTH MAINTENANCE ORGANIZATION (HMO)
01201	Patient Is Enrolled In A Hmo Plan. Delivery Charges Have Been Made To 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.					96	No agreement with entity.	1E	HEALTH MAINTENANCE ORGANIZATION (HMO)
01202	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.					187	Date(s) of service.		
01202	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.					585	Denied Charge or Non-covered Charge		
01203	Iv Sedation And General Anesthesia Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01205	Arthrotomy With Synovectomy Knee Inlcuded In Arthrotomy Knee Anterior And Posterior	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01206	V Diagnosis Code 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01206	V Diagnosis Code 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.		
01207	Rc651 And Rc652 Must Be Billed With Value Code 61 With Corresponding Msa Code	125	Submission/billing error(s). 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.)			M49	Missing/incomplete/invalid value code(s) or amount(s).	21	Missing or invalid information.		
01207	Rc651 And Rc652 Must Be Billed With Value Code 61 With Corresponding Msa Code	125	Submission/billing error(s). 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.)			M49	Missing/incomplete/invalid value code(s) or amount(s).	725	NUBC Value Code(s)		
01209	Purchase Of Supplies Related To Suction Equipment Not Allowed During The Same Month Equipment Is Rented	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
01210	Service Recouped. Supplies Related To Suction Equipment Can Not Be Billed Within The Same Calendar Month	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					259	Frequency of service.		
01210	Service Recouped. Supplies Related To Suction Equipment Can Not Be Billed Within The Same Calendar Month	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					453	Procedure Code Modifier(s) for Service(s) Rendered		
01211	Topical Application Of Fluoride Not Allowed To Bill On The Same Date Of Service As Prophylaxis Application (Age 0-20)	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01212	Tenotomy, Single Tendon Can Not Be Billed Same Date Of Service As Multiple Tendons	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01213	Prophylaxis Application Of Fluoride Not Allowed To Bill On The Same Date Of Service As Topical Application (Age 0-20)	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01215	Transplant, Hamstring Tendon To Patella; Single Tendon Not Allowed On Same Day As Multiple Tendons	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01216	Reconstruction Of Dislocating Patella Not Allowed Same As Extensor Realignment With Patellectomy And/Or Revision Removal Of Kneecap	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01217	Extensor Realignment Not Allowed Same Day As Reconstruction For Recurrent Dislocating Patella	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01218	Only One Catheter Or Reservoir/Pump Implantation 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.		
01219	Arthroplasty, Femoral Condyles Not Allowed With Repair Of Knee Joint	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01220	Revision Of Total Knee Arthroplasty, With Or Without Allograft Not Allowed Same Day As One Component	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01221	Tenotomy, Percutaneous, Achilles Tendon Not Allowed Same Day As General Anesthesia	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01224	Resubmit Claim With Special Report And Operative Notes And/ Or Medical Records	96	Non-covered charge(s). 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.) 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01224	Resubmit Claim With Special Report And Operative Notes And/ Or Medical Records	96	Non-covered charge(s). 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.) 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)		
01225	Arthrotomy, Posterior Capsular Release, Ankle Not Allowed On The Same Day As Lengthening Or Shortening Of Tendon	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01226	Biopsy, Soft Tissue Of Leg Or Ankle Area Not Allowed Same Day As Superficial	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01227	Excision, Tumor, Leg Or Ankle Area Not Allowed Same Day As Excision Benign Tumor Deep Subfacial	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01228	Repair, Flexor Tendon, Leg; Primary, Without Graft, Not Allowed Same Day As Secondary With Or Without Graft	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01229	Repair, Extensor Tendon, Leg; Primary Without Graft Not Allowed Same Day As Secondary With Or Without Graft	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01230	Tenolysis, Flexor Or Extension Tendon Not Allowed Same Day As Multiple	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01234	Single Tendon Lengthening Or Shortening Not Allowed Same Day As Multiple	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01235	Superficial And Deep Transfer Or Transplant Of Single Tendon Not Allowed On The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01236	Allow One Application Of Fluoride Within Six 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.		
01236	Allow One Application Of Fluoride Within Six Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01236	Allow One Application Of Fluoride Within Six Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N59	Please refer to your provider manual for additional program and provider information.	259	Frequency of service.		
01236	Allow One Application Of Fluoride Within Six Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N59	Please refer to your provider manual for additional program and provider information.	483	Maximum coverage amount met or exceeded for benefit period.		
01237	Repair, Secondary Disrupted Ligament, Ankle Not Allowed Same Day As Primary And Both Collateral Ligaments	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01238	Arthroplasty, Ankle; Revision Not Allowed Same Day As Repair Of Ankle	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01240	Arrest, Epiphyseal, Any Method Not Allowed Same Day As Repair Lower Leg Epiphyses	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01241	Incision And Drainage Below Fascia Not Allowed Same Day As Drainage Of Foot	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01242	Tenotomy, Percutaneous, Toe, Single Tendon Not Allowed Same Day As Multiple	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01243	Excision, Tumor, Foot Not Allowed Same Day As Benign Tumor Deep Subfascial Intramuscular	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01244	Fasciectomy, Plantar Fascia; Partial Not Allowed Same Day A Removal Of Foot Fascia	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01245	Single Or Two Segment Kyphectomy Not Allowed Same Date Of Service As Three Or More Segment Kyphectomy	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01246	Three Or More Segment Kyphectomy Not Allowed Same Date Of Service As Single Or Two Segment Kyphectomy	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01247	Ostectomy, Complete Excision Not Allowed Same Day As Partial Removal Metatarsal	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01249	Tenolysis, Extensor, Foot; Single Tendon Not Allowed Same Day As Multiple	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01250	Osteotomy, Tarsal Bones, Other Than Calcaneus Or Talus Not Allowed Same Day As Autograft	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01254	Transesophageal Echocardiography For Congenital Cardiac Abnomalies Complete Procedure Includes Components For Probe Placement And/Or Image Acquisition	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01255	Components Of Transesophageal Echocardiography Are Included In The Complete Procedure Already Paid For This Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01258	Osteotomy, With Or Without Lengthening, Other Than First Metatarsal, Not Allowed Same Day As Multiple	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01259	Reoperation, More Than 1 Month After Original Operation Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		
01259	Reoperation, More Than 1 Month After Original Operation Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		
01260	Medicaid Does Not Make Separate Payment For Professional Or Technical Component Performed On The Same Date Of Service As The Complete Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01261	Complete Procedure Not Allowed The Same Date Of Service As The Professional Or Technical Component. Professional Or Technical Component Recouped	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01262	Related Bypass Procedures Not Allowed To Bill Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01263	Medicaid Does Not Make Separate Payment For Professional Or Technical Component Performed On The Same Date Of Service As The Complete Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01264	Complete Procedure Performed On The Same Date Of Service As The Professional Or Technical Component Not Allowed. Component Recouped	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01265	Chromatography; Single Analytes Not Allowed Same Date Of Service As Multiple Analytes	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01266	Medicaid Does Not Make Separate Payment For Professional Or Technical Component Performed On The Same Date Of Service As The Complete Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01267	Complete Procedure Performed On The Same Date Of Service As The Professional Of Technical Component Not Allowed. Component Recouped	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01268	Very Long Chain Fatty Acids Not Allowed Same Date Of Service As Fatty Acids, Nonesterified	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01269	Medicaid Does Not Make Separate Payment For Professional Or Technical Component Performed On The Same Date Of Service As The Complete Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01270	Complete Procedure Performed On The Same Date Of Service As The Professional Or Technical Component Not Allowed. Component Recouped	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01271	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	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.		
01272	Medicaid Does Not Make Separate Payment For Professional Or Technical Component Performed On The Same Date Of Service As The Complete Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01273	Complete Procedure Performed On The Same Date Of Service As The Professional Or Technical Component Not Allowed. Component Recouped	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01274	For Recipients With Medicare, Medicaid Will Only Reimburse For This Dme Item If Medicare Has Allowed Or Paid	22	This care may be covered by another payer per coordination of benefits.			MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	116	Claim submitted to incorrect payer.		
01275	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.		
01278	Total Detail Primary Care Service And Therapeutic Leave Days Cannot Exceeds Total Header Pcs Days For Domiciliary Care	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M52	Missing/incomplete/invalid →from→ date(s) of service.	12	One or more originally submitted procedure codes have been combined.		
01278	Total Detail Primary Care Service And Therapeutic Leave Days Cannot Exceeds Total Header Pcs Days For Domiciliary Care	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M52	Missing/incomplete/invalid →from→ date(s) of service.	258	Days/units for procedure/revenue code.		
01278	Total Detail Primary Care Service And Therapeutic Leave Days Cannot Exceeds Total Header Pcs Days For Domiciliary Care	125	Submission/billing error(s). 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.)			M53	Missing/incomplete/invalid days or units of service.	12	One or more originally submitted procedure codes have been combined.		
01278	Total Detail Primary Care Service And Therapeutic Leave Days Cannot Exceeds Total Header Pcs Days For Domiciliary Care	125	Submission/billing error(s). 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.)			M53	Missing/incomplete/invalid days or units of service.	258	Days/units for procedure/revenue code.		
01278	Total Detail Primary Care Service And Therapeutic Leave Days Cannot Exceeds Total Header Pcs Days For Domiciliary Care	125	Submission/billing error(s). 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.)			M59	Missing/incomplete/invalid →to→ date(s) of service.	12	One or more originally submitted procedure codes have been combined.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01278	Total Detail Primary Care Service And Therapeutic Leave Days Cannot Exceeds Total Header Pcs Days For Domiciliary Care	125	Submission/billing error(s). 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.)			M59	Missing/incomplete/invalid →to→ date(s) of service.	258	Days/units for procedure/revenue code.		
01279	Medicaid Does Not Make Separate Payment For Professional Or Technical Component Performed On The Same Date Of Service As The Complete Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01280	Complete Procedure Not Allowed On The Same Date Of Service As The Professional Or Technical Component. Component Recouped	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01282	Medicaid Does Not Make Separate Payment For Professional Or Technical Component Performed On The Same Date Of Service As The Complete Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01283	Component Recouped. Complete Procedure Not Allowed On The Same Date Of Service As The Professional Or Technical Component	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01284	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01285	Components Of Basic Metabolic Panel Recouped To Allow Reimbursement Of Panel Code	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01286	This Lab Test Is Included In Fee For Basic Metabolic Panel	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	54	Duplicate of a previously processed claim/line.		
01287	Component Of Electrolyte Panel Recouped To Allow Reimbursement Of Panel Code	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	54	Duplicate of a previously processed claim/line.		
01288	This Lab Test Is Included In Fee For Electrolyte Panel	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	54	Duplicate of a previously processed claim/line.		
01289	Components Of Comprehensive Metabolic Panel Recouped To Allow Reimbursement For Panel Code	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	54	Duplicate of a previously processed claim/line.		
01290	This Lab Test Is Included In The Fee For Comprehensive Metabolic Panel	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	54	Duplicate of a previously processed claim/line.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01291	Chemiluminescent Assay And Molecular Diagnostics Not Allowed Same Date Of Service As Hiv-1 Quantification	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01292	Related Lipo Protein Procedures Not Allowed Same Dos As Primary Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01293	Service Recouped. Hiv Quantification Includes Amplified Probe Technique	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01294	Amplified Probe Technique Included In Hiv Quantification	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01295	Related Molecular Diagnostics Procedures Not Allowed Same Date Of Service As Primary Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01297	Related Patient Nucleic Acid Procedures Not Allowed Same Date Of Service As Primary Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01300	Immunization Update And Health Check Screen Not Allowed Same Day By Health Department	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01302	Simple Incision And Drainage Of Pilonidal Cyst Cannot Be Billed Same Day As Complicated Incision And Drainage Of Pilonidal Cyst	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01303	Prostate Specific Antigen (Psa); Free Not Allowed Same Date Of Service As Total	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01305	Sugars; Single Qualitative Cannot Be Billed Same Date Of Service As Multiple Qualitative	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01306	Injection,Intralesional; Up To And Including Seven Lesions Cannot Be Billed Same Day For More Than Seven Lesions	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01307	Provider Number Invalid For Cshs Code(S) Billed	125	Submission/billing error(s). 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.)			N77	Missing/incomplete/invalid designated provider number.	132	Entity's Medicaid provider id.	1P	PROVIDER
01307	Provider Number Invalid For Cshs Code(S) Billed	125	Submission/billing error(s). 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.)			N77	Missing/incomplete/invalid designated provider number.	21	Missing or invalid information.	1P	PROVIDER
01308	Debridement Of Nail(S) By Any Method(S); One To Five Cannot Be Billed Same Day For More Than Six	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01309	Sugars; Single Quanitative Cannot Be Billed Same Date Of Service As Multiple Quanitative	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01310	Only One Simple Repair Code For Each Group Of Anatomic Site Is Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01310	Only One Simple Repair Code For Each Group Of Anatomic Site Is Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01311	Simple Pulmonary Stress Testing Not Allowed Same Date Of Service As Complex Testing	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01312	Treatment Of Simple Closure Not Allowed Same Day As With Packing	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01313	First Treatment Date Is Invalid	125	Submission/billing error(s). 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.)			MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	21	Missing or invalid information.		
01314	Only One Intermediate Repair Code Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01314	Only One Intermediate Repair Code Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01315	Selective Catheter Placement, Additional 2Nd, 3Rd And Beyond Order Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		
01315	Selective Catheter Placement, Additional 2Nd, 3Rd And Beyond Order Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01316	Complex Repair, Trunk; 1.1Cm To 2.5Cm Not Allowed Same Day As 2.6Cm To 7.5Cm	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01317	Multiple Cannula Declotting Procedures Not Allowed On Same Date	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
01318	Complex Repair Scalp Arms And Or Legs; 1.1Cm To 2.5Cm Not Allowed Same Day As 2.6Cm To 7.5Cm	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01320	Complex Repair 1.1Cm To 2.5Cm Not Allowed Same Date Of Service As Related Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01321	Complex Repair Of Over 2.6Cm To 7.5Cm Not Allowed Same Date Of Service As Related Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01325	Punch Graft For Hair Transplant Not Allowed Same Day Of Service As Grafts For Hair Transplant Of More Than Fifteen Punch Grafts	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01326	Punch Graft For Hair Transplant Not Allowed Same Day Of Service As Grafts For Hair Transplant From 1 To 15 Punch Grafts	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01327	Salabrasion Not Allowed Same Day Of Service If Less Than 20Sq Cm	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01328	Salabrasion Not Allowed Same Day Of Service If Over 20Sq Cm	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01331	Complex Repair 1.0Cm Or Less Not Allowed Same Date Of Service As Related Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01332	Complex Repair 1.1Cm To 2.5Cm Not Allowed Same Date Of Service As Related Procedures	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01333	Complex Repair 2.6Cm To 7.5Cm Not Allowed Same Date Of Service As Related Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01334	Encounter: Provider Specialty Number Missing Or Invalid. Refer To Appendix A. Choose The Appropriate Specialty For The Provider Performing The Service And Resubmit	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	132	Entity's Medicaid provider id.	1P	PROVIDER
01334	Encounter: Provider Specialty Number Missing Or Invalid. Refer To Appendix A. Choose The Appropriate Specialty For The Provider Performing The Service And Resubmit	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	144	Entity's specialty license number.	1P	PROVIDER
01335	Encounter: Provider Number Missing. Enter Provider Number And Resubmit	125	Submission/billing error(s). 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.)			N77	Missing/incomplete/invalid designated provider number.	132	Entity's Medicaid provider id.	1P	PROVIDER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01336	Cap Respite Not Allowed Same Date As Adult Care Homes' Pcs Or Therapeutic Leave	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01341	Periodic Services And/Or High Risk Intervention Services Not Allowed Within The Same Calendar Month As Assertive Community Treatment Team Services					M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
01342	Assertive Community Treatment Team Services Not Allowed Within The Same Calendar Month As Periodic Services And/Or High Risk Intervention Services					M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
01345	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.		
01345	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.		
01346	Excision, Each Additional Lesion Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		
01346	Excision, Each Additional Lesion Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		
01347	Hysterectomy After Cesarean Delivery Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01347	Hysterectomy After Cesarean Delivery Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		
01356	Simple Incision And Drainage Of Abcess Cannot Be Billed Same Day As Complicated Or Multiple Incision And Drainage Of Abcess	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01361	Destruction Of Lesions By Any Method Second Through Fourteen Not Allowed Same Date Of Service As Related Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01362	Destruction Of Lesions By Any Method Fifteen Or More Not Allowed Same Date Of Service As Related Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01364	Destruction Of Warts, Molluscum Contagiosm Or Millia By Any Method Up To 14 Lesions Not Allowed Same Date Of Service As Related Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01365	Destruction Of Warts, Molluscum Contagiosum, Or Millia By Any Method Of Fifteen Or More Lesions Not Allowed Same Date Of Service As Related Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01366	Excision Of Chest Wall Tumor Without Mediastinal Lymphadenectomy Not Allowed Same Date Of Service As Related Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01367	Excision Of Chest Wall Tumor With Mediastinal Lymphadenectomy Not Allowed Same Date Of Service As Related Procedures	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01375	Fetal Nonstress Test Included In Fetal Biophysical Profile	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01378	Related Dme Procedures Are Not Allowed On The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01380	Date Of Service Overlap: Refile Claim With Charges Broken Down On Each Line For Each Date Of Service	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					277	Paper claim.		
01380	Date Of Service Overlap: Refile Claim With Charges Broken Down On Each Line For Each Date Of Service	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					279	Claim/service must be itemized		
01384	Related Strabismus Surgery Must Be Billed With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01384	Related Strabismus Surgery Must Be Billed With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		
01386	Exceeds 50 Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01386	Exceeds 50 Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01387	Related Strabismus Procedures Must Be Billed With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		
01387	Related Strabismus Procedures Must Be Billed With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		
01388	Thoracic, Additional 2Nd, 3Rd And Beyond Order Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		
01388	Thoracic, Additional 2Nd, 3Rd And Beyond Order Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		
01391	Drug Billed Is Not A Family Planning Drug. Correct And Resubmit As A New Day Claim	125	Submission/billing error(s). 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.)			N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01391	Drug Billed Is Not A Family Planning Drug. Correct And Resubmit As A New Day Claim	125	Submission/billing error(s). 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.)			N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	568	Family Planning Indicator		
01392	Additional Hour For Work/ Hardening/Conditioning Must Be Billed With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		
01392	Additional Hour For Work/ Hardening/Conditioning Must Be Billed With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		
01398	Preventive Medicine, Individual And Group Counseling Not Allowed More Than 10 Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01401	Detailed And Extensive Oral Evaluation Not Allowed Same Date Of Service As Dental Exam	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01402	Dental Exam Not Allowed On The Same Date Of Service As Detailed And Extensive Oral Evaluation	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01403	Only One Reduction Per Arch Allowed On The Same Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01403	Only One Reduction Per Arch Allowed On The Same Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01404	Private Insurance Payment Indicated On Claim. No Record Of Tpl On File. Correct Claim Or Update Recipient Tpl Using Dm 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.		
01404	Private Insurance Payment Indicated On Claim. No Record Of Tpl On File. Correct Claim Or Update Recipient Tpl Using Dm 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.		
01406	Large Volume Nebulizer Not Allowed Same Month As Compressor	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.				
01409	Hcpc Code Not Appropriate With Non-Medicare Beneficiary. Please Correct And Resubmit	125	Submission/billing error(s). 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.)			M56	Missing/incomplete/invalid payer identifier.	21	Missing or invalid information.		
01409	Hcpc Code Not Appropriate With Non-Medicare Beneficiary. Please Correct And Resubmit	125	Submission/billing error(s). 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.)			M56	Missing/incomplete/invalid payer identifier.	454	Procedure code for services rendered.		
01412	Only Six Oral Evaluations And Flouride Varnish Applications Allowed Per Recipient'S Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01415	Meniscectomy And/Or Arthrotomy Not Allowed On The Same Date Of Service As Arthroplasty	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01416	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.		
01417	Diagnostic Arthroscopy Not Allowed On The Same Date Of Service As Surgical Arthroscopy	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01418	No Payment Allowed For Special Services Procedure When E/M Service Is Not Paid For The Same Date Of Service, Same Provider	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01419	Surgical Arthroscopy (D7873, 29804) Not Allowed On The Same Date Of Service As Temporomandibular Joint	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01420	Unit Cutback - Exceeds Max Units Allowed	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
01420	Unit Cutback - Exceeds Max Units Allowed	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01420	Unit Cutback - Exceeds Max Units Allowed	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	476	Missing or invalid units of service		
01421	Repair Of Maxillofacial Soft Or Hard Tissue Defects Not Allowed On The Same Date Of Service As Related Dental Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01422	Immunization Administration Not Allowed Without Billing The Appropriate Immunization Code. Refer To The Latest Health Check Billing Guide	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	21	Missing or invalid information.		
01422	Immunization Administration Not Allowed Without Billing The Appropriate Immunization Code. Refer To The Latest Health Check Billing Guide	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	490	Other Procedure Code for Service(s) Rendered		
01432	Detail Billed With Incorrect Or No Modifier. Correct Detail And Resubmit As A New Day Claim. If Reimbursement Affected, Request A Full Recoupement And Resubmit Claim	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					453	Procedure Code Modifier(s) for Service(s) Rendered		
01434	Related Dialysis Graft Procedures Not Allowed Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01435	Related Pelvic Exenteration Procedures Not Allowed Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01436	Related Vaginectomy Procedures Not Allowed Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01437	Thyroid Carcinoma Metastases Uptake Must Be Billed Same Date Of Service As Imaging Whole Body	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01437	Thyroid Carcinoma Metastases Uptake Must Be Billed Same Date Of Service As Imaging Whole Body	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01438	Related Cardiac Blood Pool Imaging Must Be Billed Same Date Of Service As Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		
01438	Related Cardiac Blood Pool Imaging Must Be Billed Same Date Of Service As Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		
01439	Amino Acids;Single Qualitative, Not Allowed Same Date Of Service As Multiple	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01441	2 To 5 Amino Acids Not Allowed Same Dos As 6 Or More Amino Acids	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01443	Specially Priced Claim Through Div. Of Medical Assistance: Bill Type Must Be 111, 112, 113 Or 114. Correct The Bill Type And Resubmit Claim To Nctracks	125	Submission/billing error(s). 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.)			MA30	Missing/incomplete/invalid type of bill.	21	Missing or invalid information.		
01447	Stable Isotope Dilution; Single Analyte Not Allowed To Bill With Multiple	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01451	Radiologic Exam, Knee; Minimum Of 3 Views Not Allowed To Bill With Related Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01452	Radiologic Exam, Knee; Complete View Not Allowed To Bill With Related Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01453	Intravascular Ultrasound, Radiological Interpretation, Each Additional Vessel Must Be Billed With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01453	Intravascular Ultrasound, Radiological Interpretation, Each Additional Vessel Must Be Billed With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		
01455	Transluminal Balloon Angioplasty, Each Additional Peripheral Artery Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		
01455	Transluminal Balloon Angioplasty, Each Additional Peripheral Artery Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		
01456	Transluminal Artherectomy, Each Additional Peripheral Artery Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		
01456	Transluminal Artherectomy, Each Additional Peripheral Artery Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		
01457	Transluminal Artherectomy, Each Additional Visceral Artery Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		
01457	Transluminal Artherectomy, Each Additional Visceral Artery Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		
01458	Liver Imaging Procedures Not Allowed To Bill With Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01459	Liver Imaging With Vascular Flow Not Allowed To Bill With Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01460	Cardiac Blood Pool Imaging, Gated Equilibrium Not Allowed To Bill With Multiple Studies	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01461	Performance Of The Test, Physician Supervision, Report And Interpretation Included In The Cardiac Stress Test	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01462	Myocardial Perfusion Study Must Bill With Related Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01462	Myocardial Perfusion Study Must Bill With Related Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01463	Only One Special Services Visit Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01463	Only One Special Services Visit Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01464	Amino Acids, Qualitative Not Allowed To Bill With Related Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01465	Chromatography, Quantitative,Column, Single Anlyte Not Allowed To Bill With Multiple	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01466	Immunoassay For Analyte Other Than Antibody Agent Antigen, Multiple Step Method Not Allowed To Bill With Single	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01467	Immunoassay For Analyte Other Than Infectious Agent For Single Step Method Not Allowed With Multiple Step Method	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01468	Chromatography, Quantitative, Column, Multiple Analytes Not Allowed Same Date Of Service As Single Analyte	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01469	Infectious Agent Analysis Not Allowed With Hiv Resistance Testing	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01470	Molecular Diagnostics Not Allowed To Bill With Multiplex	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01471	Components Of Hiv Resistance Testing Recouped. Components Not Allowed Same Day As Hiv Resistance Testing	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01472	Iv Infusion For Therapy/Diagnosis Must Be Billed With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01472	Iv Infusion For Therapy/Diagnosis Must Be Billed With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01473	Use Of Vertical Electrodes Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01473	Use Of Vertical Electrodes Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01474	Claim Denied. Transcatheter Placement Of An Intracoronary Stent, Each Additional Vessel Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01474	Claim Denied. Transcatheter Placement Of An Intracoronary Stent, Each Additional Vessel Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01475	Percutaneous Transluminal Coronary Balloon Angioplasty; Single Vessel Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01475	Percutaneous Transluminal Coronary Balloon Angioplasty; Single Vessel Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01476	Percutaneous Balloon Valvuloplasty; Aortic Valve Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01476	Percutaneous Balloon Valvuloplasty; Aortic Valve Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01478	Doppler Echocardiography, Pulsed Wave-Complete, Must Bill With Related Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01478	Doppler Echocardiography, Pulsed Wave-Complete, Must Bill With Related Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01479	Doppler Echocardiography, Pulsed Wave-Follow Up, Must Bill With Related Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01479	Doppler Echocardiography, Pulsed Wave-Follow Up, Must Bill With Related Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01480	Pulmonary Stress Testing-Simple, Not Allowed To Bill With Complex	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01481	Cardiac Stress Test Includes Performance Of The Test, Physician Supervision, Interpretation And Report	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01482	Intraoperative Neurophysiology Testing Per Hour, Must Be Billed With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01482	Intraoperative Neurophysiology Testing Per Hour, Must Be Billed With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01483	Doppler Color Flow Velocity Mapping Must Bill With Related Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01483	Doppler Color Flow Velocity Mapping Must Bill With Related Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01487	Electronic Analysis Of Implanted Neurostimulator Pulse Generated Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01487	Electronic Analysis Of Implanted Neurostimulator Pulse Generated Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01488	Intravascular Doppler Velocity Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01488	Intravascular Doppler Velocity Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01490	Use Of Operating Microscope Not Allowed With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01491	Prolonged Physician Service In The Inpatient Setting Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01491	Prolonged Physician Service In The Inpatient Setting Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01492	Prolonged Physician Service In The Office Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01492	Prolonged Physician Service In The Office Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01493	Critical Care, Evaluation & Management Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01493	Critical Care, Evaluation & Management Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01494	Payment Included In Multiple Tendons, Bilateral	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	54	Duplicate of a previously processed claim/line.		
01495	Chemotherapy Administration, Intra-Arterial; Infusion Tech, 1 To 8 Hrs; Each Additional Hour Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01495	Chemotherapy Administration, Intra-Arterial; Infusion Tech, 1 To 8 Hrs; Each Additional Hour Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01496	Chemotherapy Administration, Intraveneous, Infusion Tech, Up To 1 Hour Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01496	Chemotherapy Administration, Intraveneous, Infusion Tech, Up To 1 Hour Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01497	Each Additional Hour Of Physician Attendance Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01497	Each Additional Hour Of Physician Attendance Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01498	Strabismus Surgery; Repair Of Detached Extraocular Muscle Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01498	Strabismus Surgery; Repair Of Detached Extraocular Muscle Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01499	Bill Medicare Part B Or Prescription Drug Plan	22	This care may be covered by another payer per coordination of benefits.			MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	116	Claim submitted to incorrect payer.		
01500	Medicaid Does Not Make Separate Payment For Procedures That Are Components Of A More Comprehensive Service Already Paid For The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01502	Components Denied. Rebill Using 81000 As The Complete Procedure, Versus Multiple Components Of Urinalysis	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01504	Cytopathology Definitive Hormonal Evaluation Related Procedure Codes Must Bill 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.		
01504	Cytopathology Definitive Hormonal Evaluation Related Procedure Codes Must Bill 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.		
01506	Procedure Denied. Bronchoplasty Procedure Only Allowed When Billed In Addition To Primary Surgery Procedure. Review Claim, Correct And Resubmit As A New Claim	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		
01506	Procedure Denied. Bronchoplasty Procedure Only Allowed When Billed In Addition To Primary Surgery Procedure. Review Claim, Correct And Resubmit As A New Claim	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		
01507	Multiple Osteotomy Of Metatarsals Not Allowed On Same Date	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01508	Multiple Arthrodesis Procedures Not Allowed On Same Date	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01509	Multiple Related Arthrodesis Procedures Not Allowed On Same Date	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01510	Multiple Capsulodesis Procedures Not Allowed On Same Date	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01511	Tenotomy, Multiple, 1 Leg Included In Bilateral	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01512	Medicaid Has Paid The Maximum Allowable For Procedure	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01514	Separate Reimbursement Not Allowed When Other Services Are Paid On The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01515	Bypass Graft, Composite Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01515	Bypass Graft, Composite Must Bill With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		
01516	Foreskin Manipulation Included In Related Procedure Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01517	Removal Of Vitreous Included In Extracapsular Cataract Procedure Same Dos	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01518	Enterolysis Included In Intestinal Procedures 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.		
01519	Component Of Procedure (Either Technical Or Professional Denied Because Same Procedure Code Has Already Been Reimbursed As A Complete Procedure For This Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01520	Technical Component Of This Procedure Has Already Been Reimbursed For This Date. Rebill For Professional Component Only	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01521	Professional Component Of This Procedure Code Has Already Been Reimbursed For This Date. Rebill For Technical Component Only	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01522	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01522	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01523	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01523	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01524	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01524	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01528	Reimbursement For Monthly Rental Of Dme Includes Payment For Related Supplies	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01529	Payment For Supplies Recouped To Allow Reimbursement For Monthly Rental Of Related Dme	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
01530	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01530	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01531	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01531	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01537	Units Cutback To Allow A Maximum Of 14 Units Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01537	Units Cutback To Allow A Maximum Of 14 Units Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01537	Units Cutback 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		
01538	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.		
01538	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.		
01541	E/M Visit Not Allowed Same Date Of Service As Clinic Visit	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01542	Clinic Visit Not Allowed Same Date Of Service As E/M Visit	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01543	Only 14 Units Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01543	Only 14 Units Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01548	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.		
01549	Recipient Must Have Received Erythropotein 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.		
01549	Recipient Must Have Received Erythropotein 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.		
01549	Recipient Must Have Received Erythropotein 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.		
01549	Recipient Must Have Received Erythropotein 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.		
01550	Dme Equipment Allowed Twice Per Year	108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01551	Only 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.		
01552	Dme Equipment Allowed Twice Per Three Years	108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01553	Refer To 1998 Cpt For Hiv Viral Load Codes And Refile	125	Submission/billing error(s). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	21	Missing or invalid information.		
01554	Service Recouped. Nursing Home/Ach Service Not Allowed During Inpatient Stay	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M2	Not paid separately when the patient is an inpatient.	258	Days/units for procedure/revenue code.		
01555	Dme Equipment Allowed Twice In Two Years	108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01565	Miscellaneous Charges Not Allowed With Prolonged Services Or Critical Care	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01567	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.		
01569	Personal Care Service Not Allowed The Same Day As High Risk Intervention-Ri Facility	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01570	Recoup Pcs When Hri-Ri Is Paid	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
01572	Units Cutback. Units Billed Exceed Maximum Units Allowed	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
01572	Units Cutback. Units Billed Exceed Maximum Units Allowed	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01573	Case Management Paid To Dmh. Recouped To Allow Payment For Case Management To Cap Provider For The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01574	Adjustment Of Immediate Dentures Not Allowed Until Six Months After Receipt Of Denture Per State Limit	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
01574	Adjustment Of Immediate Dentures Not Allowed Until Six Months After Receipt Of Denture Per State Limit	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
01575	Inpatient Services Billed Same Day, Pdn Not Allowed	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01577	Canal And Pulpotomy Procedures Not Allowed For The Same Tooth, Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01578	Pulpotomy Procedure Included In Reimbursement For Root Canal	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01579	Adjustment Of Immediate Dentures Not Allowed Until Six Months After Receipt Of Dentures Per State Limit	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
01579	Adjustment Of Immediate Dentures Not Allowed Until Six Months After Receipt Of Dentures Per State Limit	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
01581	Hospice And Pdn Not Allowed The Same Day. Contact Hospice Responsible For Patient. Refile Claim Only For Date(S) Of Service Not Covered By Hospice Benefit	96	Non-covered charge(s). 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.) 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)		
01583	Pdn Recouped-Hospice Patient. Contact Hospice Responsible For Patient. Refile Claim Only For Date(S) Of Service Not Covered By Hospice Benefit	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01584	Cap Procedure Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01584	Cap Procedure Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01585	Only One X-Ray Procedure Allowed For This Provider Within A 6 Month Period. Resubmit As An Adjustment With Documentation To Support Necessity	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01585	Only One X-Ray Procedure Allowed For This Provider Within A 6 Month Period. Resubmit As An Adjustment With Documentation To Support Necessity	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	287	Medical necessity for service.		
01585	Only One X-Ray Procedure Allowed For This Provider Within A 6 Month Period. Resubmit As An Adjustment With Documentation To Support Necessity	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	294	Supporting documentation.		
01585	Only One X-Ray Procedure Allowed For This Provider Within A 6 Month Period. Resubmit As An Adjustment With Documentation To Support Necessity	119	Benefit maximum for this time period or occurrence has been reached.			N29	Missing documentation/orders/notes/summary/report/chart.	259	Frequency of service.		
01585	Only One X-Ray Procedure Allowed For This Provider Within A 6 Month Period. Resubmit As An Adjustment With Documentation To Support Necessity	119	Benefit maximum for this time period or occurrence has been reached.			N29	Missing documentation/orders/notes/summary/report/chart.	287	Medical necessity for service.		
01585	Only One X-Ray Procedure Allowed For This Provider Within A 6 Month Period. Resubmit As An Adjustment With Documentation To Support Necessity	119	Benefit maximum for this time period or occurrence has been reached.			N29	Missing documentation/orders/notes/summary/report/chart.	294	Supporting documentation.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01586	1 Repair Of Laceration Of Palate 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.		
01586	1 Repair Of Laceration Of Palate 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		
01587	1 Repair Of Laceration Of Palate 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.		
01587	1 Repair Of Laceration Of Palate 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		
01588	Claim Denied. Treatment Has Been Rendered By Another Provider For This Date Of Service	B20	Procedure/service was partially or fully furnished by another provider.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
01589	Only One Incision/Excision 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.		
01589	Only One Incision/Excision 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		
01593	Service Denied. Exceeds The Maximum Units Allowed Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01593	Service Denied. Exceeds The Maximum Units Allowed Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01593	Service Denied. Exceeds The Maximum Units Allowed Per Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
01593	Service Denied. Exceeds The Maximum Units Allowed Per Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01596	Recipient Not Eligible For Cap Services	177	Patient has not met the required eligibility requirements.			N30	Patient ineligible for this service.	90	Entity not eligible for medical benefits for submitted dates of	IL	INSURED OR SUBSCRIBER
01598	At-Risk Case Management Service Recouped. This Service Not Allowed When Recipient Is Receiving Related Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
01599	Cap Respite Care Services Recouped. This Service Not Allowed When Recipient Is Receiving Adult Care Homes Pcs Or Therapeutic Leave					N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
01600	Recipient Disability Code Invalid - Header Level										
01603	Payment Is Included In The Allowance For Another Service Or Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	258	Days/units for procedure/revenue code.		
01604	Synagis Max 25-Day Qty Rules Exceeded. Synagis Rules Allow No More Than One 50Mg Vial And No More Than 250Mg Total In Any 25-Day Period	119	Benefit maximum for this time period or occurrence has been reached.			N59	Please refer to your provider manual for additional program and provider information.	216	Drug information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01604	Synagis Max 25-Day Qty Rules Exceeded. Synagis Rules Allow No More Than One 50Mg Vial And No More Than 250Mg Total In Any 25-Day Period	119	Benefit maximum for this time period or occurrence has been reached.			N59	Please refer to your provider manual for additional program and provider information.	259	Frequency of service.		
01604	Synagis Max 25-Day Qty Rules Exceeded. Synagis Rules Allow No More Than One 50Mg Vial And No More Than 250Mg Total In Any 25-Day Period	119	Benefit maximum for this time period or occurrence has been reached.			N59	Please refer to your provider manual for additional program and provider information.	483	Maximum coverage amount met or exceeded for benefit period.		
01605	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	IL	INSURED OR SUBSCRIBER
01606	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.	IL	INSURED OR SUBSCRIBER
01606	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.	IL	INSURED OR SUBSCRIBER
01606	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.	IL	INSURED OR SUBSCRIBER
01606	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.	IL	INSURED OR SUBSCRIBER
01606	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.	IL	INSURED OR SUBSCRIBER
01606	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.	IL	INSURED OR SUBSCRIBER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01608	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.		
01610	Family Planning Procedure Code Requires Family Planning Diagnosis. Please Correct And Resubmit	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA130	Your claim contains incomplete and/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.		
01610	Family Planning Procedure Code Requires Family Planning Diagnosis. Please Correct And Resubmit	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M76	Missing/incomplete/invalid diagnosis or condition.	21	Missing or invalid information.		
01611	Service Has Already Been Paid To Another Provider For Same Dos	B20	Procedure/service was partially or fully furnished by another provider.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01611	Service Has Already Been Paid To Another Provider For Same Dos	B20	Procedure/service was partially or fully furnished by another provider.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
01614	Exceeds Maximum Allowed For A Primary Posterior Composite On A Single Tooth	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01615	Claim Denied. Neonatal Drg Has Invalid Diagnosis	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01615	Claim Denied. Neonatal Drg Has Invalid Diagnosis	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.	488	Diagnosis code(s) for the services rendered.		
01616	The Procedure Billed Requires A Modifier 26 To Establish The Professional Component Was Billed. Correct Your Claim And Resubmit	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
01616	The Procedure Billed Requires A Modifier 26 To Establish The Professional Component Was Billed. Correct Your Claim And Resubmit	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01617	The Rendering Provider Number Cannot Be Used As A Billing Provider Number. Add The Correct Billing Provider Number An Resubmit As A New Day Claim	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N253	Missing/incomplete/invalid attending provider primary identifier.	21	Missing or invalid information.		
01618	The Lt Or Rt Modifier Must Be On The Same Detail Line As The Nu Modifier. Add The Appropriate Modifier And Resubmit The Claim	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					21	Missing or invalid information.		
01618	The Lt Or Rt Modifier Must Be On The Same Detail Line As The Nu Modifier. Add The Appropriate Modifier And Resubmit The Claim	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01619	The Lt Or Rt Modifier Must Be Billed With Procedure Code Billed. Add The Appropriate Modifier And Resubmit The Claim	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					21	Missing or invalid information.		
01619	The Lt Or Rt Modifier Must Be Billed With Procedure Code Billed. Add The Appropriate Modifier And Resubmit The Claim	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					453	Procedure Code Modifier(s) for Service(s) Rendered		
01620	Certified Rendering Provider Number Is Required When Billing This Procedure Code. Resubmit With Appropriate Rendering Number	15	The authorization number is missing, invalid, or does not apply to the billed services or provider.			N253	Missing/incomplete/invalid attending provider primary identifier.	21	Missing or invalid information.		
01620	Certified Rendering Provider Number Is Required When Billing This Procedure Code. Resubmit With Appropriate Rendering Number	15	The authorization number is missing, invalid, or does not apply to the billed services or provider.			N77	Missing/incomplete/invalid designated provider number.	21	Missing or invalid information.		
01621	Invalid Drg Grouping Due To Incorrect/Insufficient Coding. Include Weight Of Newborn On Claim And Resubmit	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					256	DRG code(s).		
01621	Invalid Drg Grouping Due To Incorrect/Insufficient Coding. Include Weight Of Newborn On Claim And Resubmit	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					273	Weight.		
01622	Intra-Nasal/Oral Administration Requires The Appropriate Intra-Nasal/Oral Immunization Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01622	Intra-Nasal/Oral Administration Requires The Appropriate Intra-Nasal/Oral Immunization Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
01623	First Intra-Nasal/Oral Immunization Administration And First Injectable Immunization Administration Not Allowed On The Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01624	Incorrect Immunization Administration Code Combination Billed. This Combination Cannot Be Billed On The Same Date Of Service. See Billing Guidelines	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	259	Frequency of service.		
01625	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01625	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01626	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
01626	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01627	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01627	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01631	Gastric Restrictive Procedures Limited To One Per Lifetime	35	Lifetime benefit maximum has been reached.			MA35	Missing/incomplete/invalid number of lifetime reserve days.	259	Frequency of service.		
01631	Gastric Restrictive Procedures Limited To One Per Lifetime	35	Lifetime benefit maximum has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01632	Physical Therapy Re-Evaluation Not Allowed Same Day As Physical Therapy Evaluation	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01633	Physical Therapy Evaluation Not Allowed Same Date Of Service As Physical Therapy Re-Evaluation	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01634	Component (Technical Or Professional) Denied. Complete Procedure Has Been Reimbursed Within 2 Years	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	454	Procedure code for services rendered.		
01635	Professional Component Has Already Been Reimbursed Within 2 Years. Re-Bill For Technical Component Only	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01636	Technical Component Has Already Been Reimbursed Within 2 Years. Re-Bill For Professional Component Only	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	454	Procedure code for services rendered.		
01638	Payment Has Been Reduced To The Same Total Reimbursement As The Three Surface Resin-Based Composite Restoration For Posterior Tooth	B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.			N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	239	Dental information.		
01638	Payment Has Been Reduced To The Same Total Reimbursement As The Three Surface Resin-Based Composite Restoration For Posterior Tooth	B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.			N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	66	Payment reflects usual and customary charges.		
01639	For Dos On & After 01-01-2009, Procedure Requires A Secondary Modifier Of Hp, Hn, Ho, Ub, U8, U7, U6 Or U5. Refer To The February 2009 Nc Medicaid Bulletin For Details	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision .	21	Missing or invalid information.		
01639	For Dos On & After 01-01-2009, Procedure Requires A Secondary Modifier Of Hp, Hn, Ho, Ub, U8, U7, U6 Or U5. Refer To The February 2009 Nc Medicaid Bulletin For Details	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision .	453	Procedure Code Modifier(s) for Service(s) Rendered		
01639	For Dos On & After 01-01-2009, Procedure Requires A Secondary Modifier Of Hp, Hn, Ho, Ub, U8, U7, U6 Or U5. Refer To The February 2009 Nc Medicaid Bulletin For Details	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N291	Missing/incomplete/invalid rendering provider secondary identifier.	21	Missing or invalid information.		
01639	For Dos On & After 01-01-2009, Procedure Requires A Secondary Modifier Of Hp, Hn, Ho, Ub, U8, U7, U6 Or U5. Refer To The February 2009 Nc Medicaid Bulletin For Details	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N291	Missing/incomplete/invalid rendering provider secondary identifier.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01640	For Dos On & After 01-01-2009, Modifiers Hp, Hn, Ho, Ub, U8 U7, U6 Or U5 Must Be Billed In The Secondary Position. Refer To The February 2009 Nc Medicaid Bulletin For Details	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	21	Missing or invalid information.		
01640	For Dos On & After 01-01-2009, Modifiers Hp, Hn, Ho, Ub, U8 U7, U6 Or U5 Must Be Billed In The Secondary Position. Refer To The February 2009 Nc Medicaid Bulletin For Details	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01640	For Dos On & After 01-01-2009, Modifiers Hp, Hn, Ho, Ub, U8 U7, U6 Or U5 Must Be Billed In The Secondary Position. Refer To The February 2009 Nc Medicaid Bulletin For Details	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N291	Missing/incomplete/invalid rendering provider secondary identifier.	21	Missing or invalid information.		
01640	For Dos On & After 01-01-2009, Modifiers Hp, Hn, Ho, Ub, U8 U7, U6 Or U5 Must Be Billed In The Secondary Position. Refer To The February 2009 Nc Medicaid Bulletin For Details	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N291	Missing/incomplete/invalid rendering provider secondary identifier.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01641	Unit Cutback. Exceeds Maximum Units Allowed Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01641	Unit Cutback. Exceeds Maximum Units Allowed Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
01641	Unit Cutback. Exceeds Maximum Units Allowed Per Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01641	Unit Cutback. Exceeds Maximum Units Allowed Per Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01642	Crossover Percentage Payments Are Not Allowed For This Provider Taxonomy	170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N95	This provider type/provider specialty may not bill this service.	585	Denied Charge or Non-covered Charge		
01646	Cap-Mr/Dd Respite Care; Facility & Institutional Not Allowed Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01648	Invalid Or Missing First Treatment Date. Resubmit Claim With Valid First Treatment Date	125	Submission/billing error(s). 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.)			MA122	Missing/incomplete/invalid initial treatment date.	21	Missing or invalid information.		
01651	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.		
01652	Care Plan Oversight Already Paid For This Calendar Month	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01653	Care Plan Oversight For Home Health Recipient Already Paid For This Calendar Month	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01654	Care Plan Oversight For Hospice Recipient Already Paid For This Calendar Month	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01655	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.		
01656	Payment For Care Plan Oversight Is Included In Dialysis Composite Rate Already Paid For This Calendar Month	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	287	Medical necessity for service.		
01656	Payment For Care Plan Oversight Is Included In Dialysis Composite Rate Already Paid For This Calendar Month	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01657	Payment For Care Plan Oversight Is Included In Dialysis Composite Rate Billed Separately For Same Calendar Month	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	287	Medical necessity for service.		
01657	Payment For Care Plan Oversight Is Included In Dialysis Composite Rate Billed Separately For Same Calendar Month	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01658	16 Psychiatric Outpatient Visits Allowed Without Prior Approval	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01659	Claim Denied. Procedure Code Must Bill With Fp Modifier	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	N95	This provider type/provider specialty may not bill this service.	21	Missing or invalid information.		
01659	Claim Denied. Procedure Code Must Bill With Fp Modifier	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	N95	This provider type/provider specialty may not bill this service.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01660	No Rate On File	204	This service/equipment/drug is not covered under the patient→s current benefit plan	CO	Contractual Obligations	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	585	Denied Charge or Non-covered Charge		
01660	No Rate On File	204	This service/equipment/drug is not covered under the patient→s current benefit plan	CO	Contractual Obligations	M76	Missing/incomplete/invalid diagnosis or condition.	585	Denied Charge or Non-covered Charge		
01661	No Other Procedure Allowed To Be Billed With T1015							732	Information submitted inconsistent with billing guidelines.		
01662	Only One Rendering Taxonomy Allowed										
01663	Prior Claim For Case Management Has Been Paid For This Month	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01664	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01664	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.		
01664	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.		
01664	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.		
01665	Secondary Thrombectomy Code Must Be Billed With A Primary Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
01665	Secondary Thrombectomy Code Must Be Billed With A Primary Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
01665	Secondary Thrombectomy Code Must Be Billed With A Primary Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01665	Secondary Thrombectomy Code Must Be Billed With A Primary Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01665	Secondary Thrombectomy Code Must Be Billed With A Primary Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	259	Frequency of service.		
01665	Secondary Thrombectomy Code Must Be Billed With A Primary Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01666	Dermagraft Limited To 4 Applications Totaling 150.00 Sq. Cm Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01666	Dermagraft Limited To 4 Applications Totaling 150.00 Sq. Cm Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01667	Only 8 Applications Or 300 Sq. Cm. Of Dermagraft Allowed Every 12 Weeks	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01672	Dme Allowed Once In Four Years For Ages 21-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01674	Diagnosis Billed Is Not Allowed As Primary Diagnosis	125	Submission/billing error(s). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	21	Missing or invalid information.		
01674	Diagnosis Billed Is Not Allowed As Primary Diagnosis	125	Submission/billing error(s). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	254	Primary diagnosis code. This change effective 11/1/2011: Principal doagnosis code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01674	Diagnosis Billed Is Not Allowed As Primary Diagnosis	125	Submission/billing error(s). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	488	Diagnosis code(s) for the services rendered.		
01674	Diagnosis Billed Is Not Allowed As Primary Diagnosis	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	21	Missing or invalid information.		
01674	Diagnosis Billed Is Not Allowed As Primary Diagnosis	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	254	Primary diagnosis code. This change effective 11/1/2011: Principal doagnosis code.		
01674	Diagnosis Billed Is Not Allowed As Primary Diagnosis	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered.		
01675	Drug Is Limited To 240 Units Per Calendar Month. Units Have Cutback To Allowable Units For This Timeframe	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		
01676	Units Cutback. Exceeds The Maximum Units Allowed Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
01676	Units Cutback. Exceeds The Maximum Units Allowed Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01676	Units Cutback. Exceeds The Maximum Units Allowed Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
01676	Units Cutback. Exceeds The Maximum Units Allowed Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01677	Service Denied. Exceeds Allowed Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01677	Service Denied. Exceeds Allowed Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01678	Related Aneurysm Procedures Not Allowed On The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01679	Provider Denied For False Claims Act	B5	Coverage/program guidelines were not met or were exceeded.			N59	Please refer to your provider manual for additional program and provider information.	585	Denied Charge or Non-covered Charge		
01679	Provider Denied For False Claims Act	B5	Coverage/program guidelines were not met or were exceeded.			N59	Please refer to your provider manual for additional program and provider information.	615	Policy Compliance Code		
01680	Service Eligible For The Affordable Care Act Enhanced Rate					N45	Payment based on authorized amount.	65	Claim/line has been paid.		
01681	Related Laminotomy Procedures Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01682	Vaccine Procedure Only Allowed 2 Per Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			N117	This service is paid only once in a patient→s lifetime.	259	Frequency of service.		
01682	Vaccine Procedure Only Allowed 2 Per Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01683	Diabetes Self Management Training Services, Individual Or Group Sessions Not Allowed More Than 20 Units Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
01683	Diabetes Self Management Training Services, Individual Or Group Sessions Not Allowed More Than 20 Units Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01684	Unit(S) Cutback. Exceeds Maximum Units Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
01684	Unit(S) Cutback. Exceeds Maximum Units Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01685	The Procedure Submitted Requires A Modifier To Identify Number Of Patients. Please Resubmit Claim With The Appropriate Modifier	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
01685	The Procedure Submitted Requires A Modifier To Identify Number Of Patients. Please Resubmit Claim With The Appropriate Modifier	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N180	This item or service does not meet the criteria for the category under which it was billed.	21	Missing or invalid information.		
01686	Diabetes Self Management Outpatient Service Not Allowed Same Day As Physician Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01686	Diabetes Self Management Outpatient Service Not Allowed Same Day As Physician Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
01686	Diabetes Self Management Outpatient Service Not Allowed Same Day As Physician Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
01686	Diabetes Self Management Outpatient Service Not Allowed Same Day As Physician Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
01687	Physician Service Not Allowed Same Day As Diabetes Self Management Outpatient Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
01687	Physician Service Not Allowed Same Day As Diabetes Self Management Outpatient Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
01687	Physician Service Not Allowed Same Day As Diabetes Self Management Outpatient Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
01687	Physician Service Not Allowed Same Day As Diabetes Self Management Outpatient Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
01689	Condition Code Indicating Medicare Override Is Not Allowed When Medicare Payment Is Also Indicated On Claim	125	Submission/billing error(s). 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.)			M44	Missing/incomplete/invalid condition code.	460	NUBC Condition Code(s)		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01690	Related Mri Procedures Not Allowed By The Same Rendering 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.		
01696	Mammography Screening Limited To One Per 5 Years	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01696	Mammography Screening Limited To One Per 5 Years	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01696	Mammography Screening Limited To One Per 5 Years	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01696	Mammography Screening Limited To One Per 5 Years	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01699	Service Is Not Consistent With Or Not Covered For This Diagnosis Or Service Does Not Match Diagnosis	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered.		
01706	Non-Physician Counseling Immunization Administration Procedure Not Allowed Same Day As Physician Counseling Immunization Administration Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01707	Procedure Recouped. Administration With Non-Physician Counseling Not Allowed Same Day As Physician Counseling	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01708	Medicare Code Editor - Mce - Age Is Invalid	6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	N129	Not eligible due to the patient's age.	475	Procedure code not valid for patient age		
01709	Medicare Code Editor - Mce - Gender Code Is Invalid	7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations			474	Procedure code and patient gender mismatch		
01709	Medicare Code Editor - Mce - Gender Code Is Invalid					M86	Service denied because payment already made for same/similar procedure within set time frame.				
01711	Portable Gaseous Oxygen System; Home Compressor Including Containers Not Allowed During Same Period As Other Related Systems/Units	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
01711	Portable Gaseous Oxygen System; Home Compressor Including Containers Not Allowed During Same Period As Other Related Systems/Units	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	455	Revenue code for services rendered.		
01711	Portable Gaseous Oxygen System; Home Compressor Including Containers Not Allowed During Same Period As Other Related Systems/Units	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
01711	Portable Gaseous Oxygen System; Home Compressor Including Containers Not Allowed During Same Period As Other Related Systems/Units	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	455	Revenue code for services rendered.		
01711	Portable Gaseous Oxygen System; Home Compressor Including Containers Not Allowed During Same Period As Other Related Systems/Units	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01711	Portable Gaseous Oxygen System; Home Compressor Including Containers Not Allowed During Same Period As Other Related Systems/Units	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	455	Revenue code for services rendered.		
01712	Other Related Systems/Units Not Allowed When Portable Gaseous Oxygen System; Home Compressor Including Containers Is Paid In History	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
01712	Other Related Systems/Units Not Allowed When Portable Gaseous Oxygen System; Home Compressor Including Containers Is Paid In History	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	455	Revenue code for services rendered.		
01712	Other Related Systems/Units Not Allowed When Portable Gaseous Oxygen System; Home Compressor Including Containers Is Paid In History	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
01712	Other Related Systems/Units Not Allowed When Portable Gaseous Oxygen System; Home Compressor Including Containers Is Paid In History	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	455	Revenue code for services rendered.		
01712	Other Related Systems/Units Not Allowed When Portable Gaseous Oxygen System; Home Compressor Including Containers Is Paid In History	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
01712	Other Related Systems/Units Not Allowed When Portable Gaseous Oxygen System; Home Compressor Including Containers Is Paid In History	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	455	Revenue code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01716	Only One Early Refill Per Year For Lost Rx Allowed	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
01718	Cbsa Code Missing, Invalid Or Does Not Match Zip Code Of The Location Where Service Was Provided. Correct Claim And Refile Or Contact Csc Provider Services	125	Submission/billing error(s). 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.)			M49	Missing/incomplete/invalid value code(s) or amount(s).	21	Missing or invalid information.	77	SERVICE LOCATION
01718	Cbsa Code Missing, Invalid Or Does Not Match Zip Code Of The Location Where Service Was Provided. Correct Claim And Refile Or Contact Csc Provider Services	125	Submission/billing error(s). 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.)			M49	Missing/incomplete/invalid value code(s) or amount(s).	500	Entity's Postal/Zip Code.	77	SERVICE LOCATION
01718	Cbsa Code Missing, Invalid Or Does Not Match Zip Code Of The Location Where Service Was Provided. Correct Claim And Refile Or Contact Csc Provider Services	125	Submission/billing error(s). 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.)			M49	Missing/incomplete/invalid value code(s) or amount(s).	726	NUBC Value Code Amount(s)	77	SERVICE LOCATION
01719	The Hospice Revenue Code Billed Must Be Billed With A Value Code Of 61 And Corresponding Cbsa Code	125	Submission/billing error(s). 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.)			M49	Missing/incomplete/invalid value code(s) or amount(s).	21	Missing or invalid information.		
01719	The Hospice Revenue Code Billed Must Be Billed With A Value Code Of 61 And Corresponding Cbsa Code	125	Submission/billing error(s). 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.)			M49	Missing/incomplete/invalid value code(s) or amount(s).	726	NUBC Value Code Amount(s)		
01721	Related Mri Procedure Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01722	Pharmacy Pa Required	197	Precertification/authorization/notification absent.			N54	Claim information is inconsistent with pre-certified/authorized services.	48	Referral/authorization.		
01723	Drug Not On Pdl. Pharmacy Pa Required	38	Services not provided or authorized by designated (network/primary care) providers.					1	For more detailed information, see remittance advice.		
01724	Secondary Thrombectomy Not Allowed Same Day As Primary Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
01724	Secondary Thrombectomy Not Allowed Same Day As Primary Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
01724	Secondary Thrombectomy Not Allowed Same Day As Primary Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
01724	Secondary Thrombectomy Not Allowed Same Day As Primary Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
01725	Related Mammography Screenings Not Allowed On The Same Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01725	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		
01725	Related Mammography Screenings Not Allowed On The Same Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
01725	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		
01726	Payment Has Been Reduced To The Same Total Reimbursement As The Intraoral Complete Series	B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.			N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	239	Dental information.		
01726	Payment Has Been Reduced To The Same Total Reimbursement As The Intraoral Complete Series	B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.			N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	66	Payment reflects usual and customary charges.		
01727	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). 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.)			M49	Missing/incomplete/invalid value code(s) or amount(s).	21	Missing or invalid information.		
01727	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). 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.)			M49	Missing/incomplete/invalid value code(s) or amount(s).	726	NUBC Value Code Amount(s)		
01728	Must Use Preferred Vendor-Prodigy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	21	Missing or invalid information.	SU	SUPPLIER/MANUFACTURER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01728	Must Use Preferred Vendor-Prodigy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	25	Entity not approved.	SU	SUPPLIER/MANUFACTURER
01729	Oral Evaluation Must Be Billed With Topical Fluoride Varnish Application	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	490	Other Procedure Code for Service(s) Rendered		
01729	Oral Evaluation Must Be Billed With Topical Fluoride Varnish Application	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	490	Other Procedure Code for Service(s) Rendered		
01731	Epsdt Monthly Personal Care Units Have Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01731	Epsdt Monthly Personal Care Units Have Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
01731	Epsdt Monthly Personal Care Units Have Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01731	Epsdt Monthly Personal Care Units Have Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
01737	Procedure/Product Denied. Product Requires Use Of Preferred Vendor-Prodigy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	21	Missing or invalid information.	SU	SUPPLIER/MANUFACTURER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01737	Procedure/Product Denied. Product Requires Use Of Preferred Vendor-Prodigy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	25	Entity not approved.	SU	SUPPLIER/MANUFACTURER
01738	Original Transaction For Rebill/Reversal Not Posted As An Ncpdp Transaction	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.				
01739	Pharmacy Prior Approval And Non-Preferred Drug Override Needed For Drug Category							252	Authorization/certification number. This change effective 11/1/2011: Entity's authorization/certification number		
01742	Only One Emergency Fill Of A Controlled Substance Allowed Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01743	Reimbursement For Restorative Procedure Code Includes All Necessary Bases And Liners	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					454	Procedure code for services rendered.		
01747	Related Radiology Procedures Not Allowed On The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01749	Related Fetal Biophysical Profile Procedures Not Allowed On The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01750	Fluoride Varnish Application Must Be Billed With Related Procedure Codes On The Same Claim	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	42	Awaiting related charges.		
01750	Fluoride Varnish Application Must Be Billed With Related Procedure Codes On The Same Claim	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	42	Awaiting related charges.		
01751	Related Prostate Specific Antigen (Psa) Procedures Not Allowed On The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01752	Repeat Billing Of The Same Quadrant For Periodontal Scaling And Root Planing Not Allowed In This Time Frame	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01753	Vitamin, Unspecified Not On Same Date Of Service As Vitamin A Or K	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01755	Drug/Implant Must Be Billed With The Appropriate Administration Code	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	465	Principal Procedure Code for Service(s) Rendered		
01758	This Procedure Included In A More Comprehensive Audiometry Procedure Billed On Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01759	Procedure Recouped To Allow Reimbursement Of More Comprehensive Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01761	Related Cap Service Not Allowed On Same Day As Cap-Mr/Dd Institutional Respite	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01762	Cap-Mr/Dd Habilitation Service Not Allowed On Same Date As Adult Day Health	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01764	Cap-Mr/Dd Group Respite And Institutional Respite Are Not Allowed On The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01765	Cap Dollar Limitation Has Been Exceeded For This Service	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)					483	Maximum coverage amount met or exceeded for benefit period.		
01766	Service Denied. Drug Allows 2000 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
01766	Service Denied. Drug Allows 2000 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01766	Service Denied. Drug Allows 2000 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
01766	Service Denied. Drug Allows 2000 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01767	Units Cutback To Maximum Allowable Amount. Limitation Has Been Reached. Submit Adjustment With Necessary Documentation	119	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.		
01767	Units Cutback To Maximum Allowable Amount. Limitation Has Been Reached. Submit Adjustment With Necessary Documentation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	294	Supporting documentation.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01768	Fee Adjusted To Maximum Allowable Amount. Limitation Met	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)					483	Maximum coverage amount met or exceeded for benefit period.		
01769	No Additional Payment Made For Hearing And/Or Vision Service. Payment Is Included In Health Check Reimbursement	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01773	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.		
01773	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		
01774	Services Included In Health Check Package	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01775	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.		
01775	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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01776	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.		
01778	Immunization Update And Health Check Screen 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.		
01780	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.		
01781	The Rx Clarification Code Specified Is Not Valid For The Recipient And Drug. Only Long-Term Care Recipients Are Valid For This Override	177	Patient has not met the required eligibility requirements.			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.	IL	INSURED OR SUBSCRIBER
01781	The Rx Clarification Code Specified Is Not Valid For The Recipient And Drug. Only Long-Term Care Recipients Are Valid For This Override	177	Patient has not met the required eligibility requirements.			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	91	Entity not eligible/not approved for dates of service.	IL	INSURED OR SUBSCRIBER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01784	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.		
01786	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.		
01786	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.		
01788	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.		
01788	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		
01789	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.		
01789	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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01793	No Payment Allowed If "Primary"Code Is Not Paid In The Past 30 Day History	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
01794	Two Quadrant Periodontal Scaling And Root Planing Allowed Per Date Of Service Unless Treatment Is Rendered In Hospital Or Ambulatory Surgical Center	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01794	Two Quadrant Periodontal Scaling And Root Planing Allowed Per Date Of Service Unless Treatment Is Rendered In Hospital Or Ambulatory Surgical Center	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01795	Previously Paid Technical Component Recouped, Complete Procedure Paid	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			MA125	Per legislation governing this program, payment constitutes payment in full.	104	Processed according to plan provisions (Plan refers to provisions that exist between the Health Plan and the Consumer or Patient)		
01797	Services Limited To 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.		
01797	Services Limited To 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.		
01799	Recipient Is Not Eligible For Medicaid Claims Payment Due To Current Living Arrangment	32	Our records indicate that this dependent is not an eligible dependent as defined.					109	Entity not eligible.	IL	INSURED OR SUBSCRIBER
01801	Claim Denied. Service Provider Id Qualifier Is Not 01	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					21	Missing or invalid information.	SJ	SERVICE PROVIDER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01801	Claim Denied. Service Provider Id Qualifier Is Not 01	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					562	Entity's National Provider Identifier (NPI).	SJ	SERVICE PROVIDER
01802	Service Provider Id Is Invalid	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					21	Missing or invalid information.	SJ	SERVICE PROVIDER
01802	Service Provider Id Is Invalid	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					562	Entity's National Provider Identifier (NPI).	SJ	SERVICE PROVIDER
01803	Service No Longer Covered By Medicaid For Recipients Who Are Also Enrolled With Medicare	22	This care may be covered by another payer per coordination of benefits.			N196	Alert: Patient eligible to apply for other coverage which may be primary.	116	Claim submitted to incorrect payer.		
01805	Claim Denied For Recipient 21 Years Of Age Or Older With Invalid Diagnosis	9	The diagnosis is inconsistent with the patient's age. 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.		
01805	Claim Denied For Recipient 21 Years Of Age Or Older With Invalid Diagnosis	9	The diagnosis is inconsistent with the patient's age. 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.		
01806	Invalid Conditon Code Billed, Verify And Resubmit With A Valid Condition Code	125	Submission/billing error(s). 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.)			M44	Missing/incomplete/invalid condition code.	431	Patient's condition/functional status at time of service.		
01806	Invalid Conditon Code Billed, Verify And Resubmit With A Valid Condition Code	125	Submission/billing error(s). 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.)			M44	Missing/incomplete/invalid condition code.	460	NUBC Condition Code(s)		
01811	Reimbursement For This Service Has Been Denied Due To The Lack Of Proper Service Endorsement Or Medicaid Participation	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	631	Reimbursement Rate		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01816	Room And Board Is Not Allowed On The Same Claim As Therapeutic Leave. Separate Services And Re-Bill	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N61	Rebill services on separate claims.	103	Claim combined with other claim(s).		
01817	Second Approach Procedure Reduced 50% Of Allowed Amount If Performed On The Same Day	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					259	Frequency of service.		
01817	Second Approach Procedure Reduced 50% Of Allowed Amount If Performed On The Same Day	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					453	Procedure Code Modifier(s) for Service(s) Rendered		
01818	Second Repair/Reconstruction Code For Skull Base Surgery Reduced 50% Of Allowed Amount If Performed On The Same Day	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					259	Frequency of service.		
01818	Second Repair/Reconstruction Code For Skull Base Surgery Reduced 50% Of Allowed Amount If Performed On The Same Day	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					453	Procedure Code Modifier(s) for Service(s) Rendered		
01819	Second Definitive Procedure Code Reduced 50% Of Allowable If Performed On The Same Day	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01819	Second Definitive Procedure Code Reduced 50% Of Allowable If Performed On The Same Day	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					453	Procedure Code Modifier(s) for Service(s) Rendered		
01820	Only One Vagotomy Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01820	Only One Vagotomy Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01821	Only One Gastrectomy Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01821	Only One Gastrectomy Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01822	Medicaid Has Paid The Maximum Allowable For This Equipment Code	108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M76	Missing/incomplete/invalid diagnosis or condition.	186	Purchase and rental price of durable medical equipment.		
01822	Medicaid Has Paid The Maximum Allowable For This Equipment Code	108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M76	Missing/incomplete/invalid diagnosis or condition.	65	Claim/line has been paid.		
01823	Payment Reduced To Equal The Purchased New Price For Each Unit Allowed. Medicaid Has Previously Paid For This Equipment Code	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			M76	Missing/incomplete/invalid diagnosis or condition.	184	Purchase price for the rented durable medical equipment.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01829	Repair Codes Billed In Conjunction With A Space Maintainer Are Paid At The Secondary Maximum Allowed Rate	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01830	Carolina Access Ii Enhanced Care Management Fee Is Reimbursed Only Through System Generated Claims	125	Submission/billing error(s). 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.)			N185	Alert: Do not resubmit this claim/service.	107	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)		
01830	Carolina Access Ii Enhanced Care Management Fee Is Reimbursed Only Through System Generated Claims	125	Submission/billing error(s). 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.)			N185	Alert: Do not resubmit this claim/service.	585	Denied Charge or Non-covered Charge		
01838	Ndc Missing. The Procedure/Product Billed Requires A Valid Ndc. Preferred Vendor-Prodigy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	21	Missing or invalid information.		
01838	Ndc Missing. The Procedure/Product Billed Requires A Valid Ndc. Preferred Vendor-Prodigy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	218	NDC number.		
01839	Invalid Ndc Submitted. Resubmit With Valid Ndc Preferred Vendor-Prodigy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	21	Missing or invalid information.		
01839	Invalid Ndc Submitted. Resubmit With Valid Ndc Preferred Vendor-Prodigy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	218	NDC number.		
01840	Claim Denied.Invalid Gc3 Match For Modifier Sc	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01840	Claim Denied.Invalid Gc3 Match For Modifier Sc	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	218	NDC number.		
01840	Claim Denied.Invalid Gc3 Match For Modifier Sc	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	21	Missing or invalid information.		
01840	Claim Denied.Invalid Gc3 Match For Modifier Sc	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	218	NDC number.		
01841	Claim Denied.Invalid Ndc For Sc Modifier	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	21	Missing or invalid information.	SU	SUPPLIER/MANUFACTURER
01841	Claim Denied.Invalid Ndc For Sc Modifier	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	25	Entity not approved.	SU	SUPPLIER/MANUFACTURER
01846	Home Health Service Recouped. Pdn Service Paid For This Date Of Service					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
01847	Claim Denied. Exceeds The Allowable 100 Medicaid Units Per 84 Day Period	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
01847	Claim Denied. Exceeds The Allowable 100 Medicaid Units Per 84 Day Period	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01847	Claim Denied. Exceeds The Allowable 100 Medicaid Units Per 84 Day Period	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
01847	Claim Denied. Exceeds The Allowable 100 Medicaid Units Per 84 Day Period	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01851	Only Two Psych Visits Allowed Per Day For Provisionally Licensed Services	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01851	Only Two Psych Visits Allowed Per Day For Provisionally Licensed Services	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01851	Only Two Psych Visits Allowed Per Day For Provisionally Licensed Services	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01851	Only Two Psych Visits Allowed Per Day For Provisionally Licensed Services	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
01853	Units Cutback To Allow The Maximum Of 2 Units Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
01853	Units Cutback To Allow The Maximum Of 2 Units Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01853	Units Cutback To Allow The Maximum Of 2 Units Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	476	Missing or invalid units of service		
01860	Ocular Photodynamic Therapy Must Be Billed With Verteporfin, Verteporfin Must Be Also Billed With Opt	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01861	Exceeds 10 Treatments Of Ocular Photodynamic Therapy Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01862	Add On Code For Concurrent Eye Must Be Billed With Primary Code For Ocular Photodynamic Therapy	107	The related or qualifying claim/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.		
01862	Add On Code For Concurrent Eye Must Be Billed With Primary Code For Ocular Photodynamic Therapy	107	The related or qualifying claim/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.		
01863	Intravenous Infusion Service Not Allowed When Ocular Photodynamic Therapy Is Paid	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	21	Missing or invalid information.		
01863	Intravenous Infusion Service Not Allowed When Ocular Photodynamic Therapy Is Paid	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01865	Dollar Amount Cutback To Maximum Allowable For This Service For This Period Of Time	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)					483	Maximum coverage amount met or exceeded for benefit period.		
01866	Physician Stand-By Service Exceeds 2 Hour Limit. If Necessary, Correct Denied Detail And Resubmit As A New Claim	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01867	Nicu Codes Allowed Once Per Day. Nicu Already Paid For This Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
01867	Nicu Codes Allowed Once Per Day. Nicu Already Paid For This Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01868	Prolonged Services Exceeds 3 Hour Maximum Allowed Per Day For All Providers. If Necessary, Correct The Number In Unit Field And Resubmit As A New Claim	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		
01868	Prolonged Services Exceeds 3 Hour Maximum Allowed Per Day For All Providers. If Necessary, Correct The Number In Unit Field And Resubmit As A New Claim	119	Benefit maximum for this time period or occurrence has been reached.					612	Per Day Limit Amount		
01869	Only One Esophagectomy Procedure Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01869	Only One Esophagectomy Procedure Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01870	Exceeds Maximum Number Of Physical Therapy Modalities, (6) 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.		
01870	Exceeds Maximum Number Of Physical Therapy Modalities, (6) Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	442	Modalities of service		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01870	Exceeds Maximum Number Of Physical Therapy Modalities, (6) 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		
01871	1 Ambulance Base Can Be Billed For Same Dos, Same Hour/Time. Correct All Units/Details On Claim And Resubmit. Multi Ple Respondents,Single Transport, If There Are Any Exception, File Adjustment With Records	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.			N29	Missing documentation/orders/notes/summary/report/chart.	258	Days/units for procedure/revenue code.		
01871	1 Ambulance Base Can Be Billed For Same Dos, Same Hour/Time. Correct All Units/Details On Claim And Resubmit. Multi Ple Respondents,Single Transport, If There Are Any Exception, File Adjustment With Records	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.			N29	Missing documentation/orders/notes/summary/report/chart.	428	Reason for transport by ambulance		
01872	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.		
01874	Only One Ambulance Miles And/Or Base Can Be Billed For The Same Dos, Same Hour/Time Of Pick Up. File An Adjustment With Records For Multiple Respondents, Single Transport Exceptions	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.			N29	Missing documentation/orders/notes/summary/report/chart.	428	Reason for transport by ambulance		
01882	Units Cut Back. Please Resubmit As An Adjustment With Anesthesia Records To Support Additional Units	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N203	Missing/incomplete/invalid anesthesia time/units	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01882	Units Cut Back. Please Resubmit As An Adjustment With Anesthesia Records To Support Additional Units	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N203	Missing/incomplete/invalid anesthesia time/units	476	Missing or invalid units of service		
01882	Units Cut Back. Please Resubmit As An Adjustment With Anesthesia Records To Support Additional Units	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N203	Missing/incomplete/invalid anesthesia time/units	522	Anesthesia Modifying Units		
01886	Service Denied. Neuraxial Labor Anesthesia/Analgesia Is Limited To One Unit Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M53	Missing/incomplete/invalid days or units of service.	476	Missing or invalid units of service		
01886	Service Denied. Neuraxial Labor Anesthesia/Analgesia Is Limited To One Unit Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	476	Missing or invalid units of service		
01887	Combine Charges And Rebill Using Major Anesthesia Code. Indicate Total Time (Units) In Column G. File Adjusment Of Previously Paid Claim If Necessary	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M51	Missing/incomplete/invalid procedure code(s).	258	Days/units for procedure/revenue code.		
01887	Combine Charges And Rebill Using Major Anesthesia Code. Indicate Total Time (Units) In Column G. File Adjusment Of Previously Paid Claim If Necessary	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M51	Missing/incomplete/invalid procedure code(s).	454	Procedure code for services rendered.		
01887	Combine Charges And Rebill Using Major Anesthesia Code. Indicate Total Time (Units) In Column G. File Adjusment Of Previously Paid Claim If Necessary	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M51	Missing/incomplete/invalid procedure code(s).	523	Anesthesia Unit Count		
01887	Combine Charges And Rebill Using Major Anesthesia Code. Indicate Total Time (Units) In Column G. File Adjusment Of Previously Paid Claim If Necessary	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N203	Missing/incomplete/invalid anesthesia time/units	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01887	Combine Charges And Rebill Using Major Anesthesia Code. Indicate Total Time (Units) In Column G. File Adjusment Of Previously Paid Claim If Necessary	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N203	Missing/incomplete/invalid anesthesia time/units	454	Procedure code for services rendered.		
01887	Combine Charges And Rebill Using Major Anesthesia Code. Indicate Total Time (Units) In Column G. File Adjusment Of Previously Paid Claim If Necessary	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N203	Missing/incomplete/invalid anesthesia time/units	523	Anesthesia Unit Count		
01888	One Anesthesia Procedure Allowed Per Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
01893	Related Therapeutic Parental Drugs Not Allowed Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01895	Claim Denied Because It Is Subject To Transfer Of Asset Penalties	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			N59	Please refer to your provider manual for additional program and provider information.	1	For more detailed information, see remittance advice.		
01898	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.		
01898	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01901	Dme Fixed Armrest Limited To One Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01901	Dme Fixed Armrest Limited To One Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01902	Dme Leg Straps Limited To One Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01902	Dme Leg Straps Limited To One Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01903	Dme Battery Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01903	Dme Battery Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01905	Dme Tires Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01905	Dme Tires Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01906	Dme Rear Wheel Assembly Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01906	Dme Rear Wheel Assembly Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01907	Dme Handrims Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01907	Dme Handrims Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01908	Dme Footplates Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01908	Dme Footplates Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01909	Dme Back Insert Limited To One Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01909	Dme Back Insert Limited To One Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01910	Dme Rear Wheel Tire Tubes Limited To Two 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.		
01910	Dme Rear Wheel Tire Tubes Limited To Two 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		
01911	Dme Caster Tires Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01911	Dme Caster Tires Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01912	Dme Battery Charger Limited To One Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01912	Dme Battery Charger Limited To One Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01913	Dme Footrests Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01913	Dme Footrests Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01914	Dme Front Caster Assembly Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01914	Dme Front Caster Assembly Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01915	Dme Armrests Limited To One Pair 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.		
01915	Dme Armrests Limited To One Pair 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		
01916	Dme Equipment Allowed Twice In 2 Yrs For Ages 00-20	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01917	Dme Equipment Allowed Twice In Three Years For Ages 21-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01918	Health Check Screening And Original Core Visit Not Allowed Same Day. Original Core Visit Denied	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
01918	Health Check Screening And Original Core Visit Not Allowed Same Day. Original Core Visit Denied	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01918	Health Check Screening And Original Core Visit Not Allowed Same Day. Original Core Visit Denied	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	187	Date(s) of service.		
01918	Health Check Screening And Original Core Visit Not Allowed Same Day. Original Core Visit Denied	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	454	Procedure code for services rendered.		
01918	Health Check Screening And Original Core Visit Not Allowed Same Day. Original Core Visit Denied	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
01918	Health Check Screening And Original Core Visit Not Allowed Same Day. Original Core Visit Denied	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01919	Dme Equipment Allowed Once In Three Years For Ages 21-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01920	Personal Care Not Allowed Same Day As Cap-Mr/Dd Supported Living	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01921	Personal Care Services Not Allowed On Same Day As Adult Care Home Personal Care Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01922	Personal Care Services Not Allowed Same Day As Cap In-Home Aide	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01923	Personal Care Services Not Allowed Same Day As Cap Attendant Care Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01924	Personal Care Services Not Allowed Same Day As Hospice	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01925	Related Services Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01926	Personal Care Service Recouped. Pcs 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01927	Private Duty Nursing Not Allowed Same Day As High Risk Residential Intervention	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
01928	Private Duty Nursing Recouped If Billed The Same Date Of Service As High Risk Residential Intervention 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.		
01930	Service Billed Is Not Valid For The Recipient'S Age	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01938	Original Core Visit Recouped. Original Core Visit Not Allowed Same Day As Health Check Screening					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
01938	Original Core Visit Recouped. Original Core Visit Not Allowed Same Day As Health Check Screening					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01938	Original Core Visit Recouped. Original Core Visit Not Allowed Same Day As Health Check Screening					N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	187	Date(s) of service.		
01938	Original Core Visit Recouped. Original Core Visit Not Allowed Same Day As Health Check Screening					N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01938	Original Core Visit Recouped. Original Core Visit Not Allowed Same Day As Health Check Screening					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
01938	Original Core Visit Recouped. Original Core Visit Not Allowed Same Day As Health Check Screening					N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01942	Terminated Drug/Discontinued Product/Service Id Number (Product Expired)	96	Non-covered charge(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					457	Non-Covered Day(s)		
01946	Service Denied, Home Health Nursing Services Not On The Same Date Of Service As Private Duty Nursing	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
01946	Service Denied, Home Health Nursing Services Not On The Same Date Of Service As Private Duty Nursing	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	585	Denied Charge or Non-covered Charge		
01946	Service Denied, Home Health Nursing Services Not On The Same Date Of Service As Private Duty Nursing	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
01946	Service Denied, Home Health Nursing Services Not On The Same Date Of Service As Private Duty Nursing	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
01946	Service Denied, Home Health Nursing Services Not On The Same Date Of Service As Private Duty Nursing	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01946	Service Denied, Home Health Nursing Services Not On The Same Date Of Service As Private Duty Nursing	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	585	Denied Charge or Non-covered Charge		
01949	Incorrect Combination Of Hcpcs 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.					21	Missing or invalid information.		
01950	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.		
01951	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.		
01952	Payment Reduced To Equal New Purchase Price. Medicaid Has Previously Paid For This Equipment Code	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.	184	Purchase price for the rented durable medical equipment.		
01953	Payment Reduced To Equal New Purchase Price. Medicaid Has Previously Paid For This Equipment Code	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.	184	Purchase price for the rented durable medical equipment.		
01954	Recipient Claim Covered Under Hospice	B9	Patient is enrolled in a Hospice.			N30	Patient ineligible for this service.	91	Entity not eligible/not approved for dates of	IL	INSURED OR SUBSCRIBER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01956	Duplicate Service Denied. If Multiple Details For The Same Procedure Were Billed, Combine Units On A Single Detail And Resubmit As A New Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
01962	Service Denied. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
01962	Service Denied. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01962	Service Denied. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
01964	Service Is Not Consistent With Or Not Covered For This Diagnosis Or Description Of Service Does Not Match Diagnosis	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered.		
01965	Service Denied. Drug Allows 100 Units Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01965	Service Denied. Drug Allows 100 Units Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01965	Service Denied. Drug Allows 100 Units Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01965	Service Denied. Drug Allows 100 Units Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01967	Multiple Procedure/Modifiers Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
01967	Multiple Procedure/Modifiers Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
01967	Multiple Procedure/Modifiers Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
01967	Multiple Procedure/Modifiers Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
01967	Multiple Procedure/Modifiers Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01967	Multiple Procedure/Modifiers Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01967	Multiple Procedure/Modifiers Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
01967	Multiple Procedure/Modifiers Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01967	Multiple Procedure/Modifiers Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01968	Fitting Of Contact Lens Must Be Billed With Appropriate Contact Lens Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M51	Missing/incomplete/invalid procedure code(s).	454	Procedure code for services rendered.		
01969	Repairs Of Aac Device Cannot Exceed $500 Per Recipient Annually	119	Benefit maximum for this time period or occurrence has been reached.			N171	Payment for repair or replacement is not covered or has exceeded the purchase price.	186	Purchase and rental price of durable medical equipment.		
01969	Repairs Of Aac Device Cannot Exceed $500 Per Recipient Annually	119	Benefit maximum for this time period or occurrence has been reached.			N171	Payment for repair or replacement is not covered or has exceeded the purchase price.	483	Maximum coverage amount met or exceeded for benefit period.		
01970	Only One Telemedicine Occurrence Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
01970	Only One Telemedicine Occurrence Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	612	Per Day Limit Amount		
01970	Only One Telemedicine Occurrence Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
01970	Only One Telemedicine Occurrence Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N20	Service not payable with other service rendered on the same date.	612	Per Day Limit Amount		
01971	Only Three Telemedicine Occurrences Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		
01971	Only Three Telemedicine Occurrences Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.					612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01972	Only One Telehealth Site Service Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
01972	Only One Telehealth Site Service Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	612	Per Day Limit Amount		
01972	Only One Telehealth Site Service Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01972	Only One Telehealth Site Service Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01973	Service Denied. Vaginal Delivery Included With Postpartum Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01973	Service Denied. Vaginal Delivery Included With Postpartum Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	585	Denied Charge or Non-covered Charge		
01973	Service Denied. Vaginal Delivery Included With Postpartum Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
01973	Service Denied. Vaginal Delivery Included With Postpartum Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01974	Aac Device, Software, Upgrades, Mounting System, Accessories And Repairs For One Recipient Not To Exceed $9,500 For A Two-Year Period	119	Benefit maximum for this time period or occurrence has been reached.			N171	Payment for repair or replacement is not covered or has exceeded the purchase price.	186	Purchase and rental price of durable medical equipment.		
01974	Aac Device, Software, Upgrades, Mounting System, Accessories And Repairs For One Recipient Not To Exceed $9,500 For A Two-Year Period	119	Benefit maximum for this time period or occurrence has been reached.			N171	Payment for repair or replacement is not covered or has exceeded the purchase price.	483	Maximum coverage amount met or exceeded for benefit period.		
01975	Qualifying Circumstance Procedure Requires Related Anesthesia Procedure To Be Paid In History	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					454	Procedure code for services rendered.		
01976	The Zip Code Applied In 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). 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.)			M49	Missing/incomplete/invalid value code(s) or amount(s).	21	Missing or invalid information.	77	SERVICE LOCATION
01976	The Zip Code Applied In 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). 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.)			M49	Missing/incomplete/invalid value code(s) or amount(s).	500	Entity's Postal/Zip Code.	77	SERVICE LOCATION
01976	The Zip Code Applied In 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). 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.)			M49	Missing/incomplete/invalid value code(s) or amount(s).	726	NUBC Value Code Amount(s)	77	SERVICE LOCATION
01977	Crna Required To Bill With Appropriate Modifier	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01977	Crna Required To Bill With Appropriate Modifier	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	453	Procedure Code Modifier(s) for Service(s) Rendered		
01978	Service Recouped. Crna Required To Bill Appropriate Modifier	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
01979	Dme Equipment Accessory Allowed Once Every 182 Days, Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01979	Dme Equipment Accessory Allowed Once Every 182 Days, Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
01980	Dme Equipment Allowed 3 Units Per 2 Years	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01981	Related Splenectomy Procedures Not Allowed Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01982	Service Recouped. Splenectomy Previously Paid As Complete Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01983	Dme Equipment Allowed 6 Units Per 2 Years	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01984	Serviced Denied. Postpartum Care Included With Vaginal Delivery	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
01984	Serviced Denied. Postpartum Care Included With Vaginal Delivery	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	585	Denied Charge or Non-covered Charge		
01984	Serviced Denied. Postpartum Care Included With Vaginal Delivery	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
01984	Serviced Denied. Postpartum Care Included With Vaginal Delivery	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
01985	Service Denied.Procedure Unit Limitation Exceeded	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01985	Service Denied.Procedure Unit Limitation Exceeded	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01985	Service Denied.Procedure Unit Limitation Exceeded	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
01985	Service Denied.Procedure Unit Limitation Exceeded	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01985	Service Denied.Procedure Unit Limitation Exceeded	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N362	The number of Days or Units of Service exceeds our acceptable maximum.	454	Procedure code for services rendered.		
01985	Service Denied.Procedure Unit Limitation Exceeded	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
01986	Claim Pended For Alternate Benefit Plan Processing							685	Claim could not complete adjudication in real time. Claim will continue processing in a batch mode. Do not resubmit		
01989	Ach-Pcs Not Allowed To Bill Revenue Code 0183 (Therapeutic Leave) For Dates Of Service Beginning 07/01/05			CO	Contractual Obligations	MA66	Missing/incomplete/invalid principal procedure code.	145	Entity's specialty/taxonomy code.	FA	FACILITY
01989	Ach-Pcs Not Allowed To Bill Revenue Code 0183 (Therapeutic Leave) For Dates Of Service Beginning 07/01/05			CO	Contractual Obligations	N188	The approved level of care does not match the procedure code submitted.	145	Entity's specialty/taxonomy code.	FA	FACILITY
01990	Component Of X-Ray (Technical Or Professional) Denied. Same Procedure Has Already Been Reimbursed As Complete Procedure Within A Year	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01990	Component Of X-Ray (Technical Or Professional) Denied. Same Procedure Has Already Been Reimbursed As Complete Procedure Within A Year	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	318	X-rays/radiology films		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01991	Complete X-Ray Procedure Denied. Technical Component Of This Procedure Has Been Reimbursed Within A Year. Rebill For Professional Component Only	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N13	Payment based on professional/technical component modifier(s).	259	Frequency of service.		
01991	Complete X-Ray Procedure Denied. Technical Component Of This Procedure Has Been Reimbursed Within A Year. Rebill For Professional Component Only	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N13	Payment based on professional/technical component modifier(s).	318	X-rays/radiology films		
01992	Complete X-Ray Procedure Denied. Professional Component Of This Procedure Already Reimbursed Within A Year. Rebill For Technical Component Only	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N13	Payment based on professional/technical component modifier(s).	259	Frequency of service.		
01992	Complete X-Ray Procedure Denied. Professional Component Of This Procedure Already Reimbursed Within A Year. Rebill For Technical Component Only	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N13	Payment based on professional/technical component modifier(s).	318	X-rays/radiology films		
01995	Pended For Mass Adjustment/Void							46	Internal review/audit.		
01995	Pended For Mass Adjustment/Void										
01997	Dental Radiograph Procedure Limited To Six Per Five Year Period	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
01997	Dental Radiograph Procedure Limited To Six Per Five Year Period	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	297	Medical notes/report.		
01997	Dental Radiograph Procedure Limited To Six Per Five Year Period	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
01997	Dental Radiograph Procedure Limited To Six Per Five Year Period	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	297	Medical notes/report.		
01998	Duplicate Claim, Same Date Of Service, Admit Hour, And Ndc Number	18	Exact duplicate claim/service (Use only with Group Code OA)			N20	Service not payable with other service rendered on the same date.	218	NDC number.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
01998	Duplicate Claim, Same Date Of Service, Admit Hour, And Ndc Number	18	Exact duplicate claim/service (Use only with Group Code OA)			N20	Service not payable with other service rendered on the same date.	54	Duplicate of a previously processed claim/line.		
02000	Procedure Limited To One Per Lifetime	35	Lifetime benefit maximum has been reached.			N117	This service is paid only once in a patient→s lifetime.	259	Frequency of service.		
02000	Procedure Limited To One Per Lifetime	35	Lifetime benefit maximum has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
02015	Infusion For Therapy Or Diagnosis Not Allowed Same Date Of Service As Prolonged Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02016	Prolonged Service Not Allowed Same Date Of Service As Infusion For Therapy Or Diagnosis	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02017	Iv Infusion For Therapy Or Diagnosis, Up To One Hour Allowed Only Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02017	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		
02019	Fetal Monitoring Recouped; Reimbursement Has Been Made To Hospital	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02020	Incision To Appendix Allowed Only Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02020	Incision To Appendix Allowed Only Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
02022	Nicu And Prolonged Services Not Allowed On The Same Date Of Service. Prolonged Service Has Already Paid For This Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
02023	Observation And Prolonged Service Not Allowed On The Same Date Of Service. Prolonged Service Already Paid For This Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
02027	State Assigned Diagnosis Code For Health Department Use Only. Correct And Resubmit As A New Day Claim	12	The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M76	Missing/incomplete/invalid diagnosis or condition.	255	Diagnosis code.		
02028	Orchiectomy Allowed Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02028	Orchiectomy Allowed Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02029	Service Recouped. Orchiectomy Previously Paid For The Same Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			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.		
02032	Daily Management Of Epidural Denied, Not Allowed Same Day As Epidural Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
02034	Daily Management Of Epidural Recouped, Not Allowed Same Day As Epidural Procedure					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
02035	Rental And Purchase Of Cap-Mr/Dd Augmentative Communication Devices Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02039	Medicaid Does Not Make Separate Payment For Procedures That Are Components Of A More Comprehensive Service Already Paid For The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
02040	Procedure Not Allowed On The Same Date Of Service As An Extraction For The Same Tooth	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02040	Procedure Not Allowed On The Same Date Of Service As An Extraction For The Same Tooth	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
02058	Related Diagnostic Ultrasounds Not Allowed Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02062	Related Fetal Non-Stress Test Not Allowed Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02066	Immunization Administration And Therapeutic Injections Not Allowed Same Day As Evaluation And Management	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02068	Related Immunization Procedures Not Allowed Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02071	Related Contraceptive Procedures Not Allowed Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02072	Service Denied. Exceeds Maximum 8 Units Allowed Per 365 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
02072	Service Denied. Exceeds Maximum 8 Units Allowed Per 365 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
02074	Only One Annual Exam Allowed Per 365 Days For Recipients 19 Years Of Age And Older	119	Benefit maximum for this time period or occurrence has been reached.			M90	Not covered more than once in a 12 month period.	259	Frequency of service.		
02080	Related Testing Procedures Not Allowed Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02091	Related Assessment / Test Not Allowed Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02098	Related Vaccines, Tetanus And Diptheria Toxoids, Are Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02098	Related Vaccines, Tetanus And Diptheria Toxoids, Are Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
02106	Multiple Details With Modifier 55 Appended Must Have The Same Date Of Service. Please Correct And Resubmit	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02107	Crossover Claims Not Allowed For Provider Taxonomy	170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N95	This provider type/provider specialty may not bill this service.	258	Days/units for procedure/revenue code.		
02112	Limitation For This Capmr Service For This Waiver Year, Has Been Exceeded	B5	Coverage/program guidelines were not met or were exceeded.					483	Maximum coverage amount met or exceeded for benefit		
02113	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.		
02113	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.		
02113	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.		
02113	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02114	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.		
02114	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.		
02114	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.		
02114	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.		
02115	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.		
02115	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.		
02115	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.		
02115	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.		
02116	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02116	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.		
02117	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.		
02117	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.		
02117	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.		
02117	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.		
02118	Sodium Fluoride Diagnostic Procedure Must Bill With A Pet Imaging Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA66	Missing/incomplete/invalid principal procedure code.	21	Missing or invalid information.		
02118	Sodium Fluoride Diagnostic Procedure Must Bill With A Pet Imaging Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA66	Missing/incomplete/invalid principal procedure code.	465	Principal Procedure Code for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02118	Sodium Fluoride Diagnostic Procedure Must Bill With A Pet Imaging Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	21	Missing or invalid information.		
02118	Sodium Fluoride Diagnostic Procedure Must Bill With A Pet Imaging Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	465	Principal Procedure Code for Service(s) Rendered		
02119	Regadenoson Must Bill With Cardiovascular Imaging Or Stress Test Procedures	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA66	Missing/incomplete/invalid principal procedure code.	21	Missing or invalid information.		
02119	Regadenoson Must Bill With Cardiovascular Imaging Or Stress Test Procedures	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA66	Missing/incomplete/invalid principal procedure code.	465	Principal Procedure Code for Service(s) Rendered		
02119	Regadenoson Must Bill With Cardiovascular Imaging Or Stress Test Procedures	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02119	Regadenoson Must Bill With Cardiovascular Imaging Or Stress Test Procedures	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	465	Principal Procedure Code for Service(s) Rendered		
02120	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.		
02120	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		
02120	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.		
02120	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		
02124	Service Recouped. Similar Incision To Appendix Previously Paid Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
02124	Service Recouped. Similar Incision To Appendix Previously Paid Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02130	Drainage Of Lymphocele To Peritoneal Cavity Allowed Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02130	Drainage Of Lymphocele To Peritoneal Cavity Allowed Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
02131	Service Recouped. Drainage Of Lymphocele To Peritoneal Cavity Previously Paid Same Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			N20	Service not payable with other service rendered on the same date.	54	Duplicate of a previously processed claim/line.		
02132	Renal Incision Allowed Only Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02132	Renal Incision Allowed Only Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
02133	Service Recouped. Renal Incision Previously Paid Under Similar Procedure For Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
02134	Only One Enterolysis Procedure Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02134	Only One Enterolysis Procedure Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02135	Service Recouped. Only One Enterolysis Procedure Per Date Of Service					N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02135	Service Recouped. Only One Enterolysis Procedure Per Date Of Service					N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
02140	One Transperineal Or Abdominal Closure Of Rectovaginal Fistula 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.		
02140	One Transperineal Or Abdominal Closure Of Rectovaginal Fistula 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		
02141	Service Recouped. Transperineal Approach Previously Paid Under Abdominal Approach To Closure Of Rectovaginal Fistula	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
02142	Radical Trachelectomy Not Allowed On The Same Date Of Service As Total Abdominal Hysterectomy	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02143	Total Abdominal Hysterectomy Not Allowed Same Date Of Service As Radical Trachelectomy	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02144	Catheterization And Contrast Material Introduction Included In Hysterosonography	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
02145	Service Recouped. Catheterization And Contrast Material Introduction Previously Paid Under Hysterosonography	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
02148	Recipient Enrolled In Medicare And Another Third Party Insurance. Rebill Totaling Insurance Amounts In Proper Field And Attach Both Vouchers	148	Information from another provider was not provided or was insufficient/incomplete. 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.)			MA92	Missing plan information for other insurance.	279	Claim/service must be itemized		
02148	Recipient Enrolled In Medicare And Another Third Party Insurance. Rebill Totaling Insurance Amounts In Proper Field And Attach Both Vouchers	148	Information from another provider was not provided or was insufficient/incomplete. 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.)			MA92	Missing plan information for other insurance.	286	Other payer's Explanation of Benefits/payment information.		
02148	Recipient Enrolled In Medicare And Another Third Party Insurance. Rebill Totaling Insurance Amounts In Proper Field And Attach Both Vouchers	148	Information from another provider was not provided or was insufficient/incomplete. 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.)			MA92	Missing plan information for other insurance.	400	Claim is out of balance		
02148	Recipient Enrolled In Medicare And Another Third Party Insurance. Rebill Totaling Insurance Amounts In Proper Field And Attach Both Vouchers	148	Information from another provider was not provided or was insufficient/incomplete. 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.)			N131	Total payments under multiple contracts cannot exceed the allowance for this service.	279	Claim/service must be itemized		
02148	Recipient Enrolled In Medicare And Another Third Party Insurance. Rebill Totaling Insurance Amounts In Proper Field And Attach Both Vouchers	148	Information from another provider was not provided or was insufficient/incomplete. 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.)			N131	Total payments under multiple contracts cannot exceed the allowance for this service.	286	Other payer's Explanation of Benefits/payment information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02148	Recipient Enrolled In Medicare And Another Third Party Insurance. Rebill Totaling Insurance Amounts In Proper Field And Attach Both Vouchers	148	Information from another provider was not provided or was insufficient/incomplete. 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.)			N131	Total payments under multiple contracts cannot exceed the allowance for this service.	400	Claim is out of balance		
02150	Single Kidney Imaging Study Not Allowed Same Date Of Service As Multiple Studies	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02151	Service Recouped. Single Kidney Imaging Study Previously Paid As Multiple Studies Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
02152	Kidney Imaging Without Pharmacological Intervention Not Allowed Same Date Of Service As Imaging With Intervention	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	258	Days/units for procedure/revenue code.		
02153	Service Recouped. Kidney Imaging Without Pharmacological Intervention Previously Paid Under Imaging With Intervention	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
02153	Service Recouped. Kidney Imaging Without Pharmacological Intervention Previously Paid Under Imaging With Intervention	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02154	Cd4 Count Not Allowed Same Date Of Service As Similar Tcell Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02155	Service Recouped. Cd4 Count Previously Paid Same Date Of Service As Similar Tcell Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
02156	Procedures Including Similar Evaluation And Management Services Allowed Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02158	Denial For Action Resason Codes 25 And 44 (Provier Number Suspended By Financial)	125	Submission/billing error(s). 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.)					126	Entity's address.	1P	PROVIDER
02158	Denial For Action Resason Codes 25 And 44 (Provier Number Suspended By Financial)	125	Submission/billing error(s). 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.)					21	Missing or invalid information.	1P	PROVIDER
02160	Rural Health Clinic Or Federally Qualified Health Center Visit Not Allowed Same Day As General Clinic Visit	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02161	General Clinic Visit Not Allowed Same Day As Rural Health Clinic Or Federally Qualified Health Center 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.		
02162	General Clinic Visit Not Allowed Same Day As Medicare Detail For Crossover Processing	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	54	Duplicate of a previously processed claim/line.		
02163	Medicare Detail For Crossover Processing Not Allowed Same Day As General Clinic Visit	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02164	Office Visit Not Allowed Same Day As General Clinic Visit	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02165	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02166	Multiple Office Visits Not Allowed For Crossover Processing	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02167	Multiple Clinic Visits Not Allowed For Crossover Processing	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02170	Office Visit Not Allowed To Bill With Clinic Visit And Federally Qualified Health Center Core Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02171	Clinic Visit And Federally Qualified Health Center Core Services Not Allowed To Bill Wit 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.		
02174	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02175	Office Visit Not Allowed Same Day As General Clinic	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02176	Medicare Payment Indicated For This Claim. Medicare Does Not Cover Procedures With Ep Modifier. Rebill Health Check Services Separately From Procedures Related To Medicare Payment	125	Submission/billing error(s). 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.)			N63	Rebill services on separate claim lines.	454	Procedure code for services rendered.		
02178	Ncpdp Origin Code Is Invalid	125	Submission/billing error(s). 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.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision .	21	Missing or invalid information.		
02179	Diagnosis Billed Is Not Valid For The Service Rendered For The Recipient'S Age Or Sex	125	Submission/billing error(s). 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.)			MA39	Missing/incomplete/invali d gender.	21	Missing or invalid information.		
02179	Diagnosis Billed Is Not Valid For The Service Rendered For The Recipient'S Age Or Sex	125	Submission/billing error(s). 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.)			MA39	Missing/incomplete/invali d gender.	86	Diagnosis and patient gender mismatch.		
02179	Diagnosis Billed Is Not Valid For The Service Rendered For The Recipient'S Age Or Sex	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invali d diagnosis or condition.	21	Missing or invalid information.		
02179	Diagnosis Billed Is Not Valid For The Service Rendered For The Recipient'S Age Or Sex	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invali d diagnosis or condition.	86	Diagnosis and patient gender mismatch.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02180	Billed Procedure Included In Similar Heart Catheterization Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
02181	Service Recouped. Heart Catheterization Previously Paid As Similar Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
02182	Maximal Voluntary Ventilation Included In Similar Pulmonary Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
02183	Service Recouped. Maximal Voluntary Ventilation Previously Paid As Related Pulmonary Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
02184	Related Service Recouped. Billed Procedure Previously Paid Under Sleep Study On Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
02185	Billed Procedure Included In Sleep Study	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02186	Cpap Ventilation Included In Sleep Staging Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
02187	Related Service Recouped. Cpap Ventilation Previously Paid As Sleep Staging Procedure On The Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
02187	Related Service Recouped. Cpap Ventilation Previously Paid As Sleep Staging Procedure On The Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
02188	Component Tests Included In Polysomnography	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	107	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)		
02188	Component Tests Included In Polysomnography	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	453	Procedure Code Modifier(s) for Service(s) Rendered		
02188	Component Tests Included In Polysomnography	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	107	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02188	Component Tests Included In Polysomnography	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
02189	Recoup Related Procedure. Polysomnography Includes Component Tests	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	107	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)		
02189	Recoup Related Procedure. Polysomnography Includes Component Tests	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	453	Procedure Code Modifier(s) for Service(s) Rendered		
02189	Recoup Related Procedure. Polysomnography Includes Component Tests	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	107	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)		
02189	Recoup Related Procedure. Polysomnography Includes Component Tests	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
02190	Single Extremity Electromyography Not Same Date Of Service As Multiple Extremities	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02191	Related Service Recouped. Single Extremity Procedure Included Under Multiple Extremity On Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
02191	Related Service Recouped. Single Extremity Procedure Included Under Multiple Extremity On Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
02192	One Discharge Management Service 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.		
02192	One Discharge Management Service 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		
02193	Related Service Recouped. Physician Standby Service Included Under Attendance At Delivery On The Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
02193	Related Service Recouped. Physician Standby Service Included Under Attendance At Delivery On The Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02194	Physician Standby Not Allowed Same Date Of Service As Attendance At Delivery	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	258	Days/units for procedure/revenue code.		
02196	Intestinal Resection With Anastomosis Allowed Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02196	Intestinal Resection With Anastomosis Allowed Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
02197	Related Service Recouped. Intestinal Resection With Anastomosis Previously Paid As Similar Procedure On The Same Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02198	Esophagogastric Fundoplasty Allowed Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02198	Esophagogastric Fundoplasty Allowed Once Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
02199	Related Service Recouped. Esophagogastric Fundoplasty Previously Paid As Similar Procedure On The Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02201	Procedure Code Billed Requires Prior Approval From Med Solutions Inc. At 800-575-4517, Option 1	125	Submission/billing error(s). 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.)			N175	Missing review organization approval.	40	Waiting for final approval.		
02218	Money Follows The Person (Mfp) - Transition Services Cutback To The Maximum Allowable Dollar Limitation Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
02219	Money Follows The Person (Mfp) - Transition Coordination Services Per Year Dollar Limitation Has Been Exceeded	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			M139	Denied services exceed the coverage limit for the demonstration.	483	Maximum coverage amount met or exceeded for benefit period.		
02220	Provider Must Respond To The Early Refill Alert In Order For The Claim To Process	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02221	An Invalid Diagnosis/Icd-9 Code Was Submitted On The Claim	125	Submission/billing error(s). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	21	Missing or invalid information.		
02221	An Invalid Diagnosis/Icd-9 Code Was Submitted On The Claim	125	Submission/billing error(s). 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.)			MA66	Missing/incomplete/invalid principal procedure code.	488	Diagnosis code(s) for the services rendered.		
02221	An Invalid Diagnosis/Icd-9 Code Was Submitted On The Claim	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02221	An Invalid Diagnosis/Icd-9 Code Was Submitted On The Claim	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered.		
02223	Diagnosis Billed Is Not Valid For The Service Rendered For The Recipient'S Age	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	21	Missing or invalid information.		
02223	Diagnosis Billed Is Not Valid For The Service Rendered For The Recipient'S Age	125	Submission/billing error(s). 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.)			M76	Missing/incomplete/invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered.		
02224	Claim Recouped. Adult Care Home/Special Care Unit-Alzheimer Not Allowed Same Day As Hospice Services					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
02224	Claim Recouped. Adult Care Home/Special Care Unit-Alzheimer Not Allowed Same Day As Hospice Services					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
02229	There Is Not An Approved Fl-2 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.		
02231	Bill Medicare Part B Carrier	22	This care may be covered by another payer per coordination of benefits.	CO	Contractual Obligations			286	Other payer's Explanation of		
02240	Case Management Services Should Be Billed Through Cap-Mr/Dd Area Programs	15	The authorization number is missing, invalid, or does not apply to the billed services or provider.			N95	This provider type/provider specialty may not bill this service.	91	Entity not eligible/not approved for dates of service.	1P	PROVIDER
02264	Testopel Is Limited To 6 Units Per 3 Months	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
02264	Testopel Is Limited To 6 Units Per 3 Months	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02264	Testopel Is Limited To 6 Units Per 3 Months	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
02264	Testopel Is Limited To 6 Units Per 3 Months	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
02265	Units Cutback. Maximum Number Of Units Per 3 Months 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.		
02265	Units Cutback. Maximum Number Of Units Per 3 Months 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.		
02275	Drug Is Limited To 240 Units Per Calendar Month. Units For This Timeframe Have Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02280	Claim Denied. Adult Care Home/Special Care Unit-Alzheimer Not Allowed Same Day As Hospice					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
02280	Claim Denied. Adult Care Home/Special Care Unit-Alzheimer Not Allowed Same Day As Hospice					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
02281	Recipient In Pace Program For All Inclusive Care Of Elderly Recipient'S Card Indicates Pace Provider Responsible For Care. Fee For Service Care Not Covered Outside Of Pace	177	Patient has not met the required eligibility requirements.					84	Service not authorized.		
02282	All Over The Counter Drugs Are In Compound					M76	Missing/incomplete/invali d diagnosis or condition.	488	Diagnosis code(s) for the services rendered.		
02286	At Least One Icd$_T$9 Diagnosis Used On The Claim Must Match A Diagnosis Specified On The Authorization Request	15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	CO	Contractual Obligations	N54	Claim information is inconsistent with pre-certified/authorized services.	255	Diagnosis code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02286	At Least One Icd$_T$9 Diagnosis Used On The Claim Must Match A Diagnosis Specified On The Authorization Request	15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	CO	Contractual Obligations			255	Diagnosis code.		
02286	At Least One Icd$_T$9 Diagnosis Used On The Claim Must Match A Diagnosis Specified On The Authorization Request	15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	CO	Contractual Obligations			84	Service not authorized.		
02287	Procedure Code(S) Are Limited To The Approved Procedure Codes On The Pa	15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	CO	Contractual Obligations	N54	Claim information is inconsistent with pre-certified/authorized services.	454	Procedure code for services rendered.		
02288	Hearing Aid Battery Supply Is Limited To A Maximum Of $35 Per Claim	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)	CO	Contractual Obligations			483	Maximum coverage amount met or exceeded for benefit period.		
02290	Claim Service Date Must Be Within The Service Date Range Approved On The Pa	15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	CO	Contractual Obligations	N54	Claim information is inconsistent with pre-certified/authorized services.	187	Date(s) of service.		
02291	Claims For Specialized Therapies Must Include The Discipline-Specific Icd-9 Diagnosis V Codes And Match The V-Code On The Pa	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations			488	Diagnosis code(s) for the services rendered.		
02292	Patients Third Party Insurance Requires Authorization From Cdsa For Payment Without Submitting Third Party Insurance Eob	133	The disposition of the claim/service is pending further review. (Use only with Group Code OA)	CO	Contractual Obligations			286	Other payer's Explanation of Benefits/payment information.		
02293	At Least One Icd$_T$9 Diagnosis Used On The Claim Must Match A Diagnosis Specified On The Prior Authorization Request	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	MA63	Missing/incomplete/invalid principal diagnosis.	255	Diagnosis code.		
02295	The Procedure Codes On The Claim Must Match The Procedure Codes On The Pa	15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	CO	Contractual Obligations	N54	Claim information is inconsistent with pre-certified/authorized services.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02296	One Of The Non-V Code Diagnosis Codes On The Claim Must Match One Of The Diagnosis Codes On The Pa	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	N54	Claim information is inconsistent with pre-certified/authorized services.	255	Diagnosis code.		
02297	Claims Must Include The Discipline-Specific Icd-9 Diagnosis V Codes Comparable To The Specialized Therapy On The Prior Authorization	15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	CO	Contractual Obligations	N54	Claim information is inconsistent with pre-certified/authorized services.	488	Diagnosis code(s) for the services rendered.		
02299	Provider Not Enrolled In Health Plan Assigned To Claim Line	239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	CO	Contractual Obligations			109	Entity not eligible.	1P	PROVIDER
02301	Referring Provider Not On File	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	N286	Missing/incomplete/invalid referring provider primary identifier.	21	Missing or invalid information.	DN	REFERRING PROVIDER
02301	Referring Provider Not On File	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	N286	Missing/incomplete/invalid referring provider primary identifier.	755	Entity's primary identifier.	DN	REFERRING PROVIDER
02302	Billing Provider Inactive Or Terminated	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.	CO	Contractual Obligations			91	Entity not eligible/not approved for dates of service.	85	BILLING PROVIDER
02303	Location Of Service Invalid For Billing Provider	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	MA115	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).	153	Entity's id number.	77	SERVICE LOCATION
02304	Ordering/Referring Provider Is Deceased On Dates Of Service	183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations			91	Entity not eligible/not approved for dates of service.	DK	ORDERING PHYSICIAN

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02305	Servicing Provider Deceased On Dates Of Service	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.	CO	Contractual Obligations			91	Entity not eligible/not approved for dates of service.	SJ	SERVICE PROVIDER
02306	Referring Provider Not In Active Status At Time Of Service	183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations			91	Entity not eligible/not approved for dates of service.	DN	REFERRING PROVIDER
02307	Prescribing Provider Not In Active Status At Time Of Service	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations			91	Entity not eligible/not approved for dates of service.	DK	ORDERING PHYSICIAN
02308	Attending/Servicing Provider Not In Active Status For Date Of Service	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.	CO	Contractual Obligations	N253	Missing/incomplete/invalid attending provider primary identifier.	91	Entity not eligible/not approved for dates of service.	71	ATTENDING PHYSICIAN
02309	Procedure Code Not On File For Dates Of Service	204	This service/equipment/drug is not covered under the patient→s current benefit plan	CO	Contractual Obligations			454	Procedure code for services rendered.		
02310	Procedure Code Is Not Covered Or Not On File For Dates Of Service	204	This service/equipment/drug is not covered under the patient→s current benefit plan	CO	Contractual Obligations			585	Denied Charge or Non-covered Charge		
02311	Revenue Code Not On File For Dates Of Service	204	This service/equipment/drug is not covered under the patient→s current benefit plan	CO	Contractual Obligations			585	Denied Charge or Non-covered Charge		
02312	Revenue Code Is Not Covered Or Not On File For Dates Of Service	204	This service/equipment/drug is not covered under the patient→s current benefit plan	CO	Contractual Obligations			585	Denied Charge or Non-covered Charge		
02313	Procedure Code Invalid For Rendering Provider Taxonomy							145	Entity's specialty/taxonomy	82	RENDERING PROVIDER
02314	Local Procedure Codes Cannot Be Submitted							454	Procedure code for services rendered.		
02324	Candida, Gardnerella And Trichomonas Are All Included In The Same Fee	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02340	Service Denied. Product No Longer Provided By Medicaid. Resubmit With Preferred Vendor-Prodigy. Refer To Http://Www.Ncdiabetes.Org For Override Instructions	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	21	Missing or invalid information.	SU	SUPPLIER/MANUFACTURER
02340	Service Denied. Product No Longer Provided By Medicaid. Resubmit With Preferred Vendor-Prodigy. Refer To Http://Www.Ncdiabetes.Org For Override Instructions	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	25	Entity not approved.	SU	SUPPLIER/MANUFACTURER
02348	Date Prescribed Is After Date Of Service	125	Submission/billing error(s). 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.)					214	Original date of prescription/orders/referral.		
02351	Claim Denied. Case Management Service With Modifier Indicating Assessment Units, Exceeds Annual Limit	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02351	Claim Denied. Case Management Service With Modifier Indicating Assessment Units, Exceeds Annual Limit	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
02369	Conflicting Abortion Or Sterilization Code On Form For Newborn	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	M44	Missing/incomplete/invalid condition code.	460	NUBC Condition Code(s)		
02375	Allow One Oral Evaluation Every 60 Days	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02375	Allow One Oral Evaluation Every 60 Days	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02424	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.		
02424	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		
02424	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.		
02424	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		
02424	Detail Reviewed By Pharmacy Department. Ndc Units Incorrect. Ndc Units Must Correspond To Submitted Hcpcs Procedure Units. Verify And Resubmit Correct Ndc Units	211	National Drug Codes (NDC) not eligible for rebate, are not covered.			M70	Alert: The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	218	NDC number.		
02424	Detail Reviewed By Pharmacy Department. Ndc Units Incorrect. Ndc Units Must Correspond To Submitted Hcpcs Procedure Units. Verify And Resubmit Correct Ndc Units	211	National Drug Codes (NDC) not eligible for rebate, are not covered.			M70	Alert: The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	476	Missing or invalid units of service		
02447	Durable Medical Equipment Allowed 8 Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02448	Durable Medical Equipment Allowed 18 Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02449	Durable Medical Equipment Allowed 6 Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02450	Durable Medical Equipment Allowed 1 Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02451	Durable Medical Equipment Allowed 1 Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02452	Durable Medical Equipment Allowed 2 Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02453	Durable Medical Equipment Allowed 2 In Three Years	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02454	Durable Medical Equipment Allowed 2 Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02455	Durable Medical Equipment Allowed 3 Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02456	Durable Medical Equipment Allowed 4 Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02457	Durable Medical Equipment Allowed 10 Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02458	Durable Medical Equipment Allowed 12 Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02459	Durable Medical Equipment Allowed 15 Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02460	Durable Medical Equipment Allowed 16 Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02461	Durable Medical Equipment Allowed 50 Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02462	Durable Medical Equipment Allowed 60 Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02463	Durable Medical Equipment Allowed 100 Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02465	Durable Medical Equipment Allowed 200 Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02466	Durable Medical Equipment Allowed 300 Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02467	Dme Allowed 720 Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02468	Durable Medical Equipment Allowed 2 Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02469	Durable Medical Equipment Allowed 4 Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02476	Service Denied. Exceeds The Limitation Of Units Allowed Per State Fiscal 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.		
02480	Units Cutback. Exceeds The Allowable 8 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.		
02480	Units Cutback. Exceeds The Allowable 8 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.		
02480	Units Cutback. Exceeds The Allowable 8 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.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02485	This Drug Contra-Indicated For Disease/Diagnosis On File For This Recipient										
02486	This Drug Has Adverse Interactions With Other Drugs On File For This Recipient										
02487	Drug Dosage Dispensed Exceeds Maximum Units (High Dose Alert)										
02488	Drug Billed Has A Duplication Of Ingredients With Prior Claim										
02489	Drug Dosage Dispensed Less Than Minimum Units (Low Dose Alert)										
02490	Drug Dispensed Has A Dur Pediatric Precaution Or Geriatric Precaution										
02491	Drug Dispensed Has A Dur Pregnancy Precaution Or Lactation Precaution										
02492	Drug Dispensed Is A Therapeutic Duplication Of Prior Claim										
02493	Drug Dispensed Is An Early Refill (Overuse Alert)										
02494	Drug Dispensed Is A Late Refill (Underuse Alert)										
02547	Procedure Not Allowed Without Modifier Fp For This Age Recipient	6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					475	Procedure code not valid for patient age		
02563	No Hcpc Code Is Required To Be Submitted On The Claim For The Specific Revenue Code							732	Information submitted inconsistent with billing guidelines.		
02600	Service And/Or Place Of Service Not Covered Under The Famil Planning Waiver	5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M77	Missing/incomplete/invalid place of service.	228	Type of bill for UB claim		
02600	Service And/Or Place Of Service Not Covered Under The Famil Planning Waiver	5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M77	Missing/incomplete/invalid place of service.	249	Place of service.		
02601	Procedure Not Covered Under The Family Planning Waiver	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M51	Missing/incomplete/invalid procedure code(s).	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02602	Invalid Or Missing First Annual Exam Date.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					21	Missing or invalid information.		
02603	Lab Procedure Date Of Service Not Within Allowed Time Frame Of Annual Exam Date	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					187	Date(s) of service.		
02603	Lab Procedure Date Of Service Not Within Allowed Time Frame Of Annual Exam Date	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					653	Test Performed Date		
02604	Diagnosis Missing Or Not Covered Under The Family Planning Waiver	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M76	Missing/incomplete/invalid diagnosis or condition.	255	Diagnosis code.		
02604	Diagnosis Missing Or Not Covered Under The Family Planning Waiver	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M76	Missing/incomplete/invalid diagnosis or condition.	345	Treatment plan for service/diagnosis		
02604	Diagnosis Missing Or Not Covered Under The Family Planning Waiver	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M76	Missing/incomplete/invalid diagnosis or condition.	557	Diagnosis Date		
02606	The Diagnosis Billed Is Not Allowed For The Combination Of Qualifying Circumstance Procedure And Anesthesia Service Billed On This Claim	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M76	Missing/incomplete/invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered.		
02607	Service Recouped. Bypass Graft Not Allowed Same Day As Bypass Graft With Endovascular Repair	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02607	Service Recouped. Bypass Graft Not Allowed Same Day As Bypass Graft With Endovascular Repair	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
02607	Service Recouped. Bypass Graft Not Allowed Same Day As Bypass Graft With Endovascular Repair	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
02610	All Unauthorized Units Have Been Exhausted. Prior Approval Is Now Required	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
02613	Exceeds The Maximum Limit Of 30 Units Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
02614	Exceeds The Maximum Limit Of 480 Units Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
02621	Service Denied. Units Have Been Exceeded Per 30 Days When Billed In An Inpatient Setting	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
02621	Service Denied. Units Have Been Exceeded Per 30 Days When Billed In An Inpatient Setting	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02622	Service Denied. Maximum Units Allowed Per Day Have Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02622	Service Denied. Maximum Units Allowed Per Day Have Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02623	Service Denied. Intranasal/ Oral Vaccine Administration Procedure Allowed One Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02623	Service Denied. Intranasal/ Oral Vaccine Administration Procedure Allowed One Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
02638	Units Cutback. Maximum Units Allowed Per Day Have Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
02638	Units Cutback. Maximum Units Allowed Per Day Have Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
02639	Units Cutback. Exceeds The Maximum Units Allowed Per 30 Days When Billed In An Inpatient Setting	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
02640	Implanon Required To Be Billed With Insertion/Removal Of Implant	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
02640	Implanon Required To Be Billed With Insertion/Removal Of Implant	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N161	This drug/service/supply is covered only when the associated service is covered.	490	Other Procedure Code for Service(s) Rendered		
02640	Implanon Required To Be Billed With Insertion/Removal Of Implant	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02640	Implanon Required To Be Billed With Insertion/Removal Of Implant	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	490	Other Procedure Code for Service(s) Rendered		
02641	Boniva Limited To 3 Units Allowed Per 90 Days	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02641	Boniva Limited To 3 Units Allowed Per 90 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
02642	Orencia Limited To 300 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02642	Orencia Limited To 300 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
02700	Procedure/Service 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.		
02706	Bypass Graft With Endovascular Repair Not Same Day As Other Bypass Graft	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
02706	Bypass Graft With Endovascular Repair Not Same Day As Other Bypass Graft	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02706	Bypass Graft With Endovascular Repair Not Same Day As Other Bypass Graft	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
02719	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.		
02720	Semen Analysis Must Be Billed Within 90 Days Of Sterilization For Mafd Recipients	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M67	Missing/incomplete/invalid other procedure code(s).	454	Procedure code for services rendered.		
02721	Action Reason Code Indicates Provider Address On File Is Incorrect	133	The disposition of the claim/service is pending further review. (Use only with Group Code OA)	CO	Contractual Obligations			126	Entity's address.		
02725	Service Denied. Echocardiography Procedure Is Not Allowed On Same Date Of Service When Billed In Conjunction With Doppler Echocardiography Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
02725	Service Denied. Echocardiography Procedure Is Not Allowed On Same Date Of Service When Billed In Conjunction With Doppler Echocardiography Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
02725	Service Denied. Echocardiography Procedure Is Not Allowed On Same Date Of Service When Billed In Conjunction With Doppler Echocardiography Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02725	Service Denied. Echocardiography Procedure Is Not Allowed On Same Date Of Service When Billed In Conjunction With Doppler Echocardiography Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02725	Service Denied. Echocardiography Procedure Is Not Allowed On Same Date Of Service When Billed In Conjunction With Doppler Echocardiography Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
02725	Service Denied. Echocardiography Procedure Is Not Allowed On Same Date Of Service When Billed In Conjunction With Doppler Echocardiography Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
02726	Service Denied. Doppler Echocardiography Procedure Is Not Allowed On Same Date Of Service When Billed In Conjunction With Echocardiography	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
02726	Service Denied. Doppler Echocardiography Procedure Is Not Allowed On Same Date Of Service When Billed In Conjunction With Echocardiography	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
02726	Service Denied. Doppler Echocardiography Procedure Is Not Allowed On Same Date Of Service When Billed In Conjunction With Echocardiography	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
02726	Service Denied. Doppler Echocardiography Procedure Is Not Allowed On Same Date Of Service When Billed In Conjunction With Echocardiography	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02726	Service Denied. Doppler Echocardiography Procedure Is Not Allowed On Same Date Of Service When Billed In Conjunction With Echocardiography	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02726	Service Denied. Doppler Echocardiography Procedure Is Not Allowed On Same Date Of Service When Billed In Conjunction With Echocardiography	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
02750	Procedure/Modifier Combination Not Allowed Same Day When Billed By Dme Provider And Paid To Cap Provider	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	21	Missing or invalid information.		
02750	Procedure/Modifier Combination Not Allowed Same Day When Billed By Dme Provider And Paid To Cap Provider	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
02750	Procedure/Modifier Combination Not Allowed Same Day When Billed By Dme Provider And Paid To Cap Provider	125	Submission/billing error(s). 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.)			N20	Service not payable with other service rendered on the same date.	21	Missing or invalid information.		
02750	Procedure/Modifier Combination Not Allowed Same Day When Billed By Dme Provider And Paid To Cap Provider	125	Submission/billing error(s). 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.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
02751	Dme Service Recouped. Not Allowed Same Day As Service Rendered For Cap Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
02751	Dme Service Recouped. Not Allowed Same Day As Service Rendered For Cap Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
02751	Dme Service Recouped. Not Allowed Same Day As Service Rendered For Cap Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02864	Claim Denied. Only One Epogen Administration Allowed Per Day. Service Has Previously Billed For This Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
02864	Claim Denied. Only One Epogen Administration Allowed Per Day. Service Has Previously Billed For This Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
02892	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
02893	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
02896	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					259	Frequency of service.		
02896	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					453	Procedure Code Modifier(s) for Service(s) Rendered		
02899	Rc452 Not Allowed Without Corresponding Rc451	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02899	Rc452 Not Allowed Without Corresponding Rc451	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	258	Days/units for procedure/revenue code.		
02901	Denied Due To Inactive Eft Status	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N24	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.	585	Denied Charge or Non-covered Charge		
02906	The Claim Pregnancy Indictor Must Be Numeric Value And It Must Be One Of The Following: 0, 1 Or 2	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02907	The Claim Other-Coverage-Code Field Must Be A Numeric Value, And It Must Be 00 - 08 For Ncpdp Format 5.1 Or 00 - 04 Or 08 For Ncpdp Format D.0	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02908	Maximum Days Supply Or Daily Dosage Have Been Exceeded	154	Payer deems the information submitted does not support this day's supply.			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02913	Pos - Processor Control Number Not Certified To Submit Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02914	Pos - Invalid Quantity. Correct Quantity To Numeric Value And Resubmit	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02915	Dispense As Written Value Invalid. Correct And Resubmit	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02917	Pos - Ucc Amount Must Be Numeric And Greater Than Zero. Correct And Resubmit	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02917	Pos - Ucc Amount Must Be Numeric And Greater Than Zero. Correct And Resubmit	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	402	Amount must be greater than zero.		
02918	Pos - Invalid Value For Compound Code. Correct And Resubmit	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02920	Pos - Level Of Service Invalid. Correct And Resubmit	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02921	Pos-Unit Dose Indicator Invalid. Correct And Resubmit	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02922	Pos -Prescription Date Invalid. Correct And Resubmit In Ccyymmdd Format	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02924	Pos - Other Payer Amount Invalid (Data Must Be Numeric). Correct And Resubmit	148	Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02925	Pos - Dur Conflict Code Invalid. Correct And Resubmit	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02926	Pos - Missing Or Invalid Professional Code. Correct And Resubmit	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02927	Pos - Dur Outcome Code Invalid. Correct And Resubmit	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02929	Point-Of-Sale Agreement Not On File	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N51	Electronic interchange agreement not on file for provider/submitter.	21	Missing or invalid information.		
02931	Pos - Days Supply Must Be Numeric And Greater Than Zero	154	Payer deems the information submitted does not support this day's supply.			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02931	Pos - Days Supply Must Be Numeric And Greater Than Zero	154	Payer deems the information submitted does not support this day's supply.			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	402	Amount must be greater than zero.		
02951	Dea On Claim Not A Valid Dea. Contact Prescriber And Refile With Correct Dea	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02954	Reimbursement Was Made On Previously Paid Detail. Payment Is Determined By # Of Automated Tests Billed. Payment And # Of Units Are Reflected On 1St Detail	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
02960	Missing Or Invalid Compound Ingredient Ndc	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02962	Missing Or Invalid Prescription Number Qualifier. Only A Value Of '1' Is Accepted	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02963	Missing Or Invalid Product Id Qualifier, Only A Ndc Qualifier Code Of '03' Is Accepted	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02964	Missing Or Invalid Prior Authorization Type Code	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02965	Partial Fill/Completion Transactions Are Not Supported	B5	Coverage/program guidelines were not met or were exceeded.			M53	Missing/incomplete/invalid days or units of service.	107	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02966	Missing Or Invalid Prescriber Id Qualifier. The Valid Qualifier Is 12	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02967	Only A Value Of 1, 2 Or 3 Can Be Submitted For Coordination Of Benefits/Other Payments Count	148	Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02968	Invalid Other Payer Coverage Type. 01, 02, 03, 98 Or 99 Are The Only Valid Types Accepted	148	Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02969	Invalid Other Payer Amount Count. Other Payer Amount Count Must Be A Numeric Value Between 1 And 9	148	Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02970	Missing Or Invalid Other Payer Amount Paid Qualifier. Must Be 01 Through 08, 98, 99 Or Blank	148	Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02976	Missing Or Invalid Compound Ingredient Quantity	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02977	Missing Or Invalid Compound Product Id Qualifier, Only A Ndc Qualifier Code Of '3' Is Accepted	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02978	Missing Or Invalid Compound Ingredient Cost	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02979	Actual Compound Ingredient Does Not Match Ingredient Count Submitted On Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02981	Compound Ingredient Count Must Be Greater Than '0' And Less Than '26'	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
02981	Compound Ingredient Count Must Be Greater Than '0' And Less Than '26'	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	402	Amount must be greater than zero.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02985	Daw - Prescriber Invalid With Family Planning Waiver	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	216	Drug information.		
02987	Depo Provera Can Only Be Dispensed Every 77 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.		
02988	Anesthesia Services Must Be Appended With Modifiers Aa, Ad Qk, Qx, Qy, Or Qz	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					453	Procedure Code Modifier(s) for Service(s) Rendered		
02989	Resubmit Claim With Appropriate Directed Anesthesia Modifier	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					21	Missing or invalid information.		
02989	Resubmit Claim With Appropriate Directed Anesthesia Modifier	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
02992	Tpl Amounts Should Not Include Medicare Payment	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.		
02992	Tpl Amounts Should Not Include Medicare Payment	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		
02992	Tpl Amounts Should Not Include Medicare Payment	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/payment		
02992	Tpl Amounts Should Not Include Medicare Payment	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		
02992	Tpl Amounts Should Not Include Medicare Payment	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/payment information.		
02992	Tpl Amounts Should Not Include Medicare Payment	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		
02999	Rc599 And Rc679 Not Allowed On Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03001	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). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
03007	Patient Facility Id Is Missing, Invalid, Or Unresolved. Verify Patient Facility Id And Resubmit As New Claim Or Contact Csc Provider Services If Id Is Correct	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.	21	Missing or invalid information.	FA	FACILITY
03007	Patient Facility Id Is Missing, Invalid, Or Unresolved. Verify Patient Facility Id And Resubmit As New Claim Or Contact Csc Provider Services If Id Is Correct	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.	562	Entity's National Provider Identifier (NPI).	FA	FACILITY
03007	Patient Facility Id Is Missing, Invalid, Or Unresolved. Verify Patient Facility Id And Resubmit As New Claim Or Contact Csc Provider Services If Id Is Correct	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N253	Missing/incomplete/invalid attending provider primary identifier.	21	Missing or invalid information.	FA	FACILITY
03007	Patient Facility Id Is Missing, Invalid, Or Unresolved. Verify Patient Facility Id And Resubmit As New Claim Or Contact Csc Provider Services If Id Is Correct	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N253	Missing/incomplete/invalid attending provider primary identifier.	562	Entity's National Provider Identifier (NPI).	FA	FACILITY
03011	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.		
03011	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03012	Add-On Code Must Be Billed With A Paid 'Primary' Procedure In Series For Reimbursement	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
03012	Add-On Code Must Be Billed With A Paid 'Primary' Procedure In Series For Reimbursement	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03013	Add-On Code Must Be Billed With A Paid 'Primary' Procedure In Series For Reimbursement	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
03013	Add-On Code Must Be Billed With A Paid 'Primary' Procedure In Series For Reimbursement	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03014	Add-On Code Must Be Billed With A Paid 'Primary' Procedure In Series For Reimbursement	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
03014	Add-On Code Must Be Billed With A Paid 'Primary' Procedure In Series For Reimbursement	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03015	Simple And Complex Repair For Resection Of Diaphragm Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03016	Only One Appendectomy Procedure Allowed Per Recipient Lifetime	119	Benefit maximum for this time period or occurrence has been reached.			N117	This service is paid only once in a patient→s lifetime.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03017	Only One Laparoscopy Procedure Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
03017	Only One Laparoscopy Procedure Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
03018	Multiple Initial Inguinal Hernia Repair Procedures Not Allowed On The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03019	Multiple Recurrent Inguinal Hernia Repair Procedures Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03020	Multiple Procedures Related To Renal Cysts Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03021	Related Pyeloplasty Procedures Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03022	Related Donor Nephrectomy Procedure Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03023	Related Nephrectomy Procedures Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03024	Related Nephroureterectomy Procedure Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03025	Related Ureterolithotomy Pprocedure Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03026	Related Sling Operation For Stress Incontinence Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03027	Related Orchiopexy Procedure Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03028	Related Male Genital Procedure Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03029	Related Spermatic Procedure Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03030	Related Male Genital Procedure Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03031	Related Vaginal Hysterectomy Procedure Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03032	Related Cranial Neurostimulator Procedure Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03033	Add-On Code Must Be Billed With A Paid 'Primary' Procedure In Series For Reimbursement	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
03033	Add-On Code Must Be Billed With A Paid 'Primary' Procedure In Series For Reimbursement	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03034	Cervical Or Thoracic Injection Limited To 18 Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
03034	Cervical Or Thoracic Injection Limited To 18 Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
03035	Add-On Code Must Be Billed With A Paid 'Primary' Procedure In Series For Reimbursement	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
03035	Add-On Code Must Be Billed With A Paid 'Primary' Procedure In Series For Reimbursement	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03036	Lumbar Or Sacral Injection Limited To 5 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03036	Lumbar Or Sacral Injection Limited To 5 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		
03037	Add-On Code Must Be Billed With A Paid 'Primary' Procedure In Series For Reimbursement	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
03037	Add-On Code Must Be Billed With A Paid 'Primary' Procedure In Series For Reimbursement	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03039	Add-On Code Must Be Billed With A Paid 'Primary' Procedure In Series For Reimbursement	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
03039	Add-On Code Must Be Billed With A Paid 'Primary' Procedure In Series For Reimbursement	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03041	Add-On Code Must Be Billed With A Paid 'Primary' Procedure In Series For Reimbursement	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
03041	Add-On Code Must Be Billed With A Paid 'Primary' Procedure In Series For Reimbursement	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03042	Procedure Limited To 18 Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03042	Procedure Limited To 18 Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
03043	Related Lab Panel Code Already Billed For Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03044	Components Of Renal Function Panel Recouped To Allow Reimbursement Of Panel Code	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03045	Components Of Renal Function Panel Included In Reimbursemen 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.		
03046	Related Cardioversion Procedure Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03047	Internal And External Cardioversion Procedure Not Allowed O Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03048	Related Cardiac Recorder Procedure Not Allowed On Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03049	Component Of This Procedure Denied. This Procedure Already Reimbursed As A Complete Procedure On The Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03050	Complete Procedure Denied. Technical Component Of This Procedure Already Reimbursed For The Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03051	Complete Procedure Denied. Professional Component Of This Procedure Already Reimbursed For The Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03052	Components Of Hepatic Function Panel Recouped To Allow Reimbursement Of Panel Code	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03053	Components Of Hepatic Function Panel Included In Reimbursement Of Panel Code	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03073	Levulan Kerastick, 1 Stick Equals 1 Unit. Medicaid Allows 2 Units Within 8 Weeks	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
03073	Levulan Kerastick, 1 Stick Equals 1 Unit. Medicaid Allows 2 Units Within 8 Weeks	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
03073	Levulan Kerastick, 1 Stick Equals 1 Unit. Medicaid Allows 2 Units Within 8 Weeks	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
03073	Levulan Kerastick, 1 Stick Equals 1 Unit. Medicaid Allows 2 Units Within 8 Weeks	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
03074	Levulan Kerastick Not Allowed Unless Procedure 96567 Is Paid. Please Bill J7308 With Procedure 96567	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
03074	Levulan Kerastick Not Allowed Unless Procedure 96567 Is Paid. Please Bill J7308 With Procedure 96567	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		
03074	Levulan Kerastick Not Allowed Unless Procedure 96567 Is Paid. Please Bill J7308 With Procedure 96567	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03074	Levulan Kerastick Not Allowed Unless Procedure 96567 Is Paid. Please Bill J7308 With Procedure 96567	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		
03085	Units Cutback. Procedure Limitation Exceeded Per Day	B5	Coverage/program guidelines were not met or were exceeded.			M53	Missing/incomplete/invalid days or units of service.	259	Frequency of service.		
03085	Units Cutback. Procedure Limitation Exceeded Per Day	B5	Coverage/program guidelines were not met or were exceeded.			M53	Missing/incomplete/invalid days or units of service.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03085	Units Cutback. Procedure Limitation Exceeded Per Day	B5	Coverage/program guidelines were not met or were exceeded.			M53	Missing/incomplete/invalid days or units of service.	612	Per Day Limit Amount		
03087	Molecular Diagnosis Add On Must Be Billed With Primary Procedure	125	Submission/billing error(s). 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.)			M51	Missing/incomplete/invalid procedure code(s).	259	Frequency of service.		
03087	Molecular Diagnosis Add On Must Be Billed With Primary Procedure	125	Submission/billing error(s). 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.)			M51	Missing/incomplete/invalid procedure code(s).	454	Procedure code for services rendered.		
03088	Auditory Pre-Lingual Hearing Loss Not Allowed With Post-Lingual Hearing Loss Procedure	125	Submission/billing error(s). 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.)			M51	Missing/incomplete/invalid procedure code(s).	259	Frequency of service.		
03088	Auditory Pre-Lingual Hearing Loss Not Allowed With Post-Lingual Hearing Loss Procedure	125	Submission/billing error(s). 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.)			M51	Missing/incomplete/invalid procedure code(s).	454	Procedure code for services rendered.		
03088	Auditory Pre-Lingual Hearing Loss Not Allowed With Post-Lingual Hearing Loss Procedure	125	Submission/billing error(s). 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.)			M51	Missing/incomplete/invalid procedure code(s).	459	Lifetime Reserve Day(s)		
03100	The Taxonomy Code For The Rendering Provider Is Missing Or Invalid	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)								
03101	The Taxonomy Code For The Attending Provider Is Missing Or Invalid	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					145	Entity's specialty/taxonomy code.	82	RENDERING PROVIDER
03101	The Taxonomy Code For The Attending Provider Is Missing Or Invalid	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					21	Missing or invalid information.	82	RENDERING PROVIDER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03102	The Taxonomy Code For The Billing Provider Is Missing Or Invalid	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					145	Entity's specialty/taxonomy code.	85	BILLING PROVIDER
03102	The Taxonomy Code For The Billing Provider Is Missing Or Invalid	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					21	Missing or invalid information.	85	BILLING PROVIDER
03103	The National Provider Identifier Submitted Is Not Found On The Provider File	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					21	Missing or invalid information.	87	PAY-TO PROVIDER
03103	The National Provider Identifier Submitted Is Not Found On The Provider File	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					562	Entity's National Provider Identifier (NPI).	87	PAY-TO PROVIDER
03105	The National Provider Identifier Submitted For The Prescribing Provider Is Missing Or Invalid	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N31	Missing/incomplete/invalid prescribing provider identifier.	21	Missing or invalid information.	1P	PROVIDER
03105	The National Provider Identifier Submitted For The Prescribing Provider Is Missing Or Invalid	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N31	Missing/incomplete/invalid prescribing provider identifier.	562	Entity's National Provider Identifier (NPI).	1P	PROVIDER
03106	The National Provider Identifier Submitted For The Prescribing Provider Cannot Be The Same As The Pharmacy'S National Provider Identifier	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					21	Missing or invalid information.	87	PAY-TO PROVIDER
03106	The National Provider Identifier Submitted For The Prescribing Provider Cannot Be The Same As The Pharmacy'S National Provider Identifier	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					562	Entity's National Provider Identifier (NPI).	87	PAY-TO PROVIDER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03107	Claim Should Contain Npi Only Without The Medicaid Provider Number As Provider Is Not Atypical	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					21	Missing or invalid information.	87	PAY-TO PROVIDER
03107	Claim Should Contain Npi Only Without The Medicaid Provider Number As Provider Is Not Atypical	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					562	Entity's National Provider Identifier (NPI).	87	PAY-TO PROVIDER
03108	Exceeds Number Of Units Allowed Per 84 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
03109	Units Cutback. Number Of Units Allowed Per 84 Days Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
03112	Supply Of Injectable Contrast Material For Use In Echocardigraphy, Requires Echocardiography Procedure On The Same Day	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	258	Days/units for procedure/revenue code.		
03112	Supply Of Injectable Contrast Material For Use In Echocardigraphy, Requires Echocardiography Procedure On The Same Day	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	258	Days/units for procedure/revenue code.		
03113	Provider Ineligible On Service Date-Under Review										
03115	Type Of Bill Submitted Is Not Valid. Correct And Resubmit As A New Day Claim	125	Submission/billing error(s). 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.)			MA30	Missing/incomplete/invalid type of bill.	21	Missing or invalid information.		
03115	Type Of Bill Submitted Is Not Valid. Correct And Resubmit As A New Day Claim	125	Submission/billing error(s). 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.)			MA30	Missing/incomplete/invalid type of bill.	228	Type of bill for UB claim		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03116	Revenue Code Billed Has Been Labeled As Reserved	125	Submission/billing error(s). 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.)			MA30	Missing/incomplete/invalid type of bill.	21	Missing or invalid information.		
03116	Revenue Code Billed Has Been Labeled As Reserved	125	Submission/billing error(s). 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.)			MA30	Missing/incomplete/invalid type of bill.	228	Type of bill for UB claim		
03117	Point Of Origin Is Invalid	125	Submission/billing error(s). 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.)			MA30	Missing/incomplete/invalid type of bill.	21	Missing or invalid information.		
03117	Point Of Origin Is Invalid	125	Submission/billing error(s). 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.)			MA30	Missing/incomplete/invalid type of bill.	228	Type of bill for UB claim		
03118	Procedure Limited To 230 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.		
03118	Procedure Limited To 230 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
03118	Procedure Limited To 230 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.		
03118	Procedure Limited To 230 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.	483	Maximum coverage amount met or exceeded for benefit period.		
03119	High Tech Image And Ultrasound, Same Revenue Code Or Procedure Code Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03119	High Tech Image And Ultrasound, Same Revenue Code Or Procedure Code Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
03119	High Tech Image And Ultrasound, Same Revenue Code Or Procedure Code Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
03119	High Tech Image And Ultrasound, Same Revenue Code Or Procedure Code Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
03120	Previously Billed Procedure. Surgery Performed During Follow Up Of Another Surgery Requires A Modifier. If Current Claim Is Original Procedure, Request Recoupment Of Paid Detail And Resubmit With Modifier	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	21	Missing or invalid information.		
03121	Units Cutback, Exceeds The Allowable 230 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.		
03121	Units Cutback, Exceeds The Allowable 230 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.		
03122	Maximum Units Per Year For This Procedure Have Been Paid	119	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.		
03125	Mental Health/Substance Abuse Targeted Case Management Not Allowed With Related Behavioral Health Services Procedures For The Same Calendar Week	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03125	Mental Health/Substance Abuse Targeted Case Management Not Allowed With Related Behavioral Health Services Procedures For The Same Calendar Week	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03126	Behavorial Health Services Not Allowed With Other Related Mental Health/Substance Abuse Targeted Case Management Procedures For Same Calendar Week	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03126	Behavorial Health Services Not Allowed With Other Related Mental Health/Substance Abuse Targeted Case Management Procedures For Same Calendar Week	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
03140	Wrong Pharmacy For Controlled Substance							585	Denied Charge or Non-covered Charge		
03162	Drug Limited To 1800 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
03162	Drug Limited To 1800 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
03163	Behavioral Health Service Not Allowed On Same Date Of Service As Related Service Performed By Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03164	Behavioral Health Hcpcs Code Not Allowed On Same Date Of Service As Related Cpt Code Paid To The Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03170	Cpt Code Not Allowed Same Date Of Service As Related Behavioral Health Hcpcs Code Paid For Same Date Of Service To Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03183	Rc450 Not Allowed Same Day, Same Hour As Rc451 Or Rc452	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03184	Rc451 And Rc452 Not Allowed Same Day, Same Hour As Rc450	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
03195	Claim Denied. Essure Follow Up Guidelines Not Met	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision .	259	Frequency of service.		
03196	Procedure/Modifier Combination With This Diagnosis Is Allowed Only Once Per Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
03196	Procedure/Modifier Combination With This Diagnosis Is Allowed Only Once Per Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			M86	Service denied because payment already made for same/similar procedure within set time frame.	488	Diagnosis code(s) for the services rendered.		
03196	Procedure/Modifier Combination With This Diagnosis Is Allowed Only Once Per Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			N117	This service is paid only once in a patient→s lifetime.	259	Frequency of service.		
03196	Procedure/Modifier Combination With This Diagnosis Is Allowed Only Once Per Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			N117	This service is paid only once in a patient→s lifetime.	488	Diagnosis code(s) for the services rendered.		
03197	Other Sterilization Procedure Is Not Allowed When Essure Procedure Is Paid In History For This Recipient	119	Benefit maximum for this time period or occurrence has been reached.			M79	Missing/incomplete/invalid charge.	259	Frequency of service.		
03197	Other Sterilization Procedure Is Not Allowed When Essure Procedure Is Paid In History For This Recipient	119	Benefit maximum for this time period or occurrence has been reached.			M79	Missing/incomplete/invalid charge.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03197	Other Sterilization Procedure Is Not Allowed When Essure Procedure Is Paid In History For This Recipient	119	Benefit maximum for this time period or occurrence has been reached.			M79	Missing/incomplete/invalid charge.	492	Other Procedure Date		
03197	Other Sterilization Procedure Is Not Allowed When Essure Procedure Is Paid In History For This Recipient	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
03197	Other Sterilization Procedure Is Not Allowed When Essure Procedure Is Paid In History For This Recipient	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
03197	Other Sterilization Procedure Is Not Allowed When Essure Procedure Is Paid In History For This Recipient	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	492	Other Procedure Date		
03215	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.		
03215	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.		
03215	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.		
03215	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.		
03235	This Hri-Rh Not Authorized To Receive Hri Payment For This Recipient For Dates Of Service 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.	QC	PATIENT
03236	This Recipient Not Authorized On The Dates Of Service Billed For High Risk Intervention Coverage	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.	QC	PATIENT

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03237	The Level Of High Risk Intervention Coverage Billed Is Not Authorized For This Recipient	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.	QC	PATIENT
03239	This Hospice Provider Is Not Authorized To Receive 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.	1P	PROVIDER
03240	Nctracks Has Not Been Notifed 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.	QC	PATIENT
03241	Nctracks 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.	QC	PATIENT
03269	Therapeutic, Prophylactic Or Diagnostic Injection Must Be Billed With The Primary Procedure Code By The Same Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03270	Therapeutic, Prophylactic Or Diagnostic Injection Must Be Billed With A Related Radiopharmaceutical Code By The Same Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03298	Recipient Not Enrolled With This Hmo Provider For This Date Of Service							139	Entity's health maintenance provider id	IL	INSURED OR SUBSCRIBER
03300	Procedure Cutback. Limited To 1 Per Instance Of Breast Cancer	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
03300	Procedure Cutback. Limited To 1 Per Instance Of Breast Cancer	119	Benefit maximum 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.		
03325	Delivery Of Placenta, External Cephalic Version Or Special Miscellaneous Services Included In Fee For Delivery. Services Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	585	Denied Charge or Non-covered Charge		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03325	Delivery Of Placenta, External Cephalic Version Or Special Miscellaneous Services Included In Fee For Delivery. Services Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	585	Denied Charge or Non-covered Charge		
03332	School Based Health Center'S Sponsoring Provider Is Not Eligible. Please Contact Dwch For More Information	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.			N95	This provider type/provider specialty may not bill this service.	109	Entity not eligible.	82	RENDERING PROVIDER
03392	Claim Denied. Respiratory Therapy In A School Setting Limited To 2 Dates Of Service Per Recipient Every 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.		
03395	Procedure Code Allowed Once Per Gestational Period	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
03398	Pmh Initial Assessment And Pmh Post Partum Assessment, Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
03409	Ach Providers Must Use Diagnosis Code V60.6 When Billing Type Of Bill 893 Or 897. Verify And Resubmit Correct Diagnosis Code As A New Day Claim	12	The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	MA63	Missing/incomplete/invalid principal diagnosis.	255	Diagnosis code.		
03410	Provider Taxonomy Cannot Bill Enhanced Benefit Services On Or After Date Of Service March 20, 2006					N95	This provider type/provider specialty may not bill this service.	187	Date(s) of service.		
03410	Provider Taxonomy Cannot Bill Enhanced Benefit Services On Or After Date Of Service March 20, 2006					N95	This provider type/provider specialty may not bill this service.	454	Procedure code for services rendered.		
03412	Provider Taxonomy Cannot Bill Enhanced Benefit Services On Or After Date Of Service July 1, 2006					N95	This provider type/provider specialty may not bill this service.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03412	Provider Taxonomy Cannot Bill Enhanced Benefit Services On Or After Date Of Service July 1, 2006					N95	This provider type/provider specialty may not bill this service.	454	Procedure code for services rendered.		
03413	Provider Taxonomy Cannot Bill Enhanced Benefit Services On And After Date Of Service October 1, 2006					N95	This provider type/provider specialty may not bill this service.	187	Date(s) of service.		
03413	Provider Taxonomy Cannot Bill Enhanced Benefit Services On And After Date Of Service October 1, 2006					N95	This provider type/provider specialty may not bill this service.	454	Procedure code for services rendered.		
03414	Incorrect Number Of Units Billed For This Service. Please Correct And Resubmit With Corrected Units	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N142	The original claim was denied. Resubmit a new claim, not a replacement claim.	476	Missing or invalid units of service		
03425	Community Support Not Allowed Same Calendar Week As Mental Health/Substance Abuse Tcm	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
03425	Community Support Not Allowed Same Calendar Week As Mental Health/Substance Abuse Tcm	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
03437	Service Denied. Dme Equipment Not To Exceed Three Units In Three Years, Ages 000-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
03438	Units Cutback. Dme Equipment Not To Exceed Three Units In Three Years, Ages 000-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
03505	Units Billed For Epogen Procedure For The Calendar Month Have Been Exceeded. 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03506	Epogen Services Are Limited To 13 Occurrences Per Calendar Month. Adjustment Request Including Medical Records Is Required For Review Of Additional Occurrences	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
03507	Units Billed For Epogen Procedure Have Been Cutback To The Maximum Allowable Units	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
03508	Units Billed For Epogen Procedure Have Been Cutback To The Maximum Allowable Units	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
03509	Epogen Procedures Are Specific To Units Billed. Correct Claim If Necessary To Combine Units Under One Appropriate Procedure And File As An Adjustment	A1	Claim/Service denied. 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.)			M50	Missing/incomplete/invalid revenue code(s).	21	Missing or invalid information.		
03509	Epogen Procedures Are Specific To Units Billed. Correct Claim If Necessary To Combine Units Under One Appropriate Procedure And File As An Adjustment	A1	Claim/Service denied. 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.)			M50	Missing/incomplete/invalid revenue code(s).	476	Missing or invalid units of service		
03510	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.		
03511	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.		
03511	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.		
03511	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03511	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.		
03522	Rendering Provider Not Eligible During Dates Of Service	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.	CO	Contractual Obligations	N290	Missing/incomplete/invalid rendering provider primary identifier.	91	Entity not eligible/not approved for dates of service.	82	RENDERING PROVIDER
03523	Rendering Provider Not On File	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	N290	Missing/incomplete/invalid rendering provider primary identifier.	26	Entity not found.	82	RENDERING PROVIDER
03537	Family Planning Indicator Invalid Or Missing	125	Submission/billing error(s). 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.)	CO	Contractual Obligations			568	Family Planning Indicator		
03552	All Asc Dental Procedures Must Bill The Same Modifier							239	Dental information.		
03562	Missing Or Invalid Ndc Code, Or Not On File, For Compound							218	NDC number.		
03575	Drg Code Not On Pricing File	A8	Ungroupable DRG.	CO	Contractual Obligations			256	DRG code(s).		
03585	Drug Therapy Procedure(S) Not Allowed Unless Billed In Addition To Hit Nursing Service Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M51	Missing/incomplete/invalid procedure code(s).	454	Procedure code for services rendered.		
03585	Drug Therapy Procedure(S) Not Allowed Unless Billed In Addition To Hit Nursing Service Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
03585	Drug Therapy Procedure(S) Not Allowed Unless Billed In Addition To Hit Nursing Service Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03601	Amount Charged Is Zero	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	M79	Missing/incomplete/invalid charge.	178	Submitted charges.		
03602	Principal Diagnosis Code Is Missing	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	MA63	Missing/incomplete/invalid principal diagnosis.	254	Primary diagnosis code. This change effective 11/1/2011: Principal doagnosis code.		
03603	Accident Code Is Not Valid - Header	125	Submission/billing error(s). 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.)					633	Related Causes Code (Accident, auto accident, employment)		
03605	Attending/Rendering Provider Id Required	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	N290	Missing/incomplete/invalid rendering provider primary identifier.	153	Entity's id number.	SJ	SERVICE PROVIDER
03606	Zero Units Submitted	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	M53	Missing/incomplete/invalid days or units of service.	258	Days/units for procedure/revenue code.		
03608	Resubmit An 837 Transaction With The Medicare Data Elements Populated.	125	Submission/billing error(s). 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.)	CO	Contractual Obligations			286	Other payer's Explanation of Benefits/payment information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03609	Invalid Encounter Control Number - Encounter Only	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	M47	Missing/incomplete/invalid internal or document control number.	559	Document Control Identifier	85	BILLING PROVIDER
03610	Other Insurance Claim Paid Amount Not Equal To Sum Of Line Paid Amount(S)	125	Submission/billing error(s). 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.)	CO	Contractual Obligations			400	Claim is out of balance		
03611	Encounter Claim - Procedure Code Is Missing	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	M51	Missing/incomplete/invalid procedure code(s).	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03611	Encounter Claim - Procedure Code Is Missing	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	M51	Missing/incomplete/invalid procedure code(s).	454	Procedure code for services rendered.		
03612	Principal Procedure Is Missing	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	MA66	Missing/incomplete/invalid principal procedure code.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03612	Principal Procedure Is Missing	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	MA66	Missing/incomplete/invalid principal procedure code.	465	Principal Procedure Code for Service(s) Rendered		
03613	Missing Primary Diagnosis Code	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	MA63	Missing/incomplete/invalid principal diagnosis.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03613	Missing Primary Diagnosis Code	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	MA63	Missing/incomplete/invalid principal diagnosis.	254	Primary diagnosis code. This change effective 11/1/2011: Principal doagnosis code.		
03614	Encounter Payment Type Code Invalid										
03615	Invalid Oral Cavity Code	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	N346	Missing/incomplete/invalid oral cavity designation code.	21	Missing or invalid information.		
03615	Invalid Oral Cavity Code	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	N346	Missing/incomplete/invalid oral cavity designation code.	242	Tooth numbers, surfaces, and/or quadrants involved.		
03618	Invalid Submitted Units	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	M53	Missing/incomplete/invalid days or units of service.	476	Missing or invalid units of service		
03626	Community Support Recouped, Not Allowed Same Calendar Week As Mh/Sa Tcm	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03626	Community Support Recouped, Not Allowed Same Calendar Week As Mh/Sa Tcm	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
03628	Billing Provider Id Is Required	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	21	Missing or invalid information.	85	BILLING PROVIDER
03628	Billing Provider Id Is Required	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	562	Entity's National Provider Identifier (NPI).	85	BILLING PROVIDER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03629	Missing Or Invalid Present On Admission Code	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	N434	Missing/Incomplete/Invalid Present on Admission indicator.	21	Missing or invalid information.		
03629	Missing Or Invalid Present On Admission Code	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	N434	Missing/Incomplete/Invalid Present on Admission indicator.	688	Present on Admission Indicator for reported diagnosis code(s).		
03630	Invalid Emergency Code	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	471	Were services related to an emergency?		
03636	Other Insurance Payment Amount Is Invalid	125	Submission/billing error(s). 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.)	CO	Contractual Obligations			286	Other payer's Explanation of Benefits/payment information.		
03641	Admitting Diagnosis Code Missing	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	MA65	Missing/incomplete/invalid admitting diagnosis.	232	Admitting diagnosis.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03642	Principle Procedure Code Date Invalid	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	N303	Missing/incomplete/invalid principal procedure date.	486	Principal Procedure Date		
03644	Discharge Hours Invalid	125	Submission/billing error(s). 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.)	CO	Contractual Obligations			233	Hospital discharge hour.		
03652	Discharge Date Prior To Admission Date	125	Submission/billing error(s). 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.)	CO	Contractual Obligations			190	Facility discharge date		
03653	Beginning Date Of Service Is Prior To The Admission Date							189	Facility admission date		
03657	Service End Date Prior To The Stay Deny Date	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	N299	Missing/incomplete/invalid occurrence date(s).	720	NUBC Occurrence Code Date(s)		
03660	Stay Deny Effective Date Prior To Admission Date	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	N299	Missing/incomplete/invalid occurrence date(s).	720	NUBC Occurrence Code Date(s)		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03663	Admit Number Missing	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	M47	Missing/incomplete/invalid internal or document control number.	478	Claim submitter's identifier	QC	PATIENT
03665	Patient Still In Hospital But Discharge Date Or Hour Present On Claim	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	N50	Missing/incomplete/invalid discharge information.	234	Patient discharge status.		
03666	Patient Has Been Discharged, But Date And Hour Are Missing	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	N50	Missing/incomplete/invalid discharge information.	190	Facility discharge date		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03667	Patient Born In Hospital - Year Of Birth Differs From Admission Year	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	N340	Missing/incomplete/invalid subscriber birth date.	158	Entity's date of birth.	QC	PATIENT
03668	Admission Code Invalid When Epsdt Is Found	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	M44	Missing/incomplete/invalid condition code.	460	NUBC Condition Code(s)		
03670	Conflicting Accident Code Found On Claim For Newborn Recipeint	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	M45	Missing/incomplete/invalid occurrence code(s).	719	NUBC Occurrence Code(s)		
03671	Disability Code On Institutional Claim For Newborn	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	M44	Missing/incomplete/invalid condition code.	460	NUBC Condition Code(s)		
03672	Family Planning Indicator Found On Newborn Claim	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	M44	Missing/incomplete/invalid condition code.	460	NUBC Condition Code(s)		
03673	Invalid Alternate Care Date	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	N300	Missing/incomplete/invalid occurrence span date(s).	722	NUBC Occurrence Span Code Date(s)		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03674	Therapeutic Leave Days Not On Separate Line	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	N63	Rebill services on separate claim lines.	456	Covered Day(s)	7C	PLACE OF OCCURRENCE
03675	Hospital Leave Days Not On Separate Line For Institutional Claim	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	N63	Rebill services on separate claim lines.	456	Covered Day(s)		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03677	No Primiary Diagnosis Info For Status Admission Or Discharge	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	M76	Missing/incomplete/invalid diagnosis or condition.	254	Primary diagnosis code. This change effective 11/1/2011: Principal doagnosis code.		
03679	Medicare Coinsurance Days Incorrect	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.	458	Coinsurance Day(s)		
03680	Error In Calculation Of Non Covered Days	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	MA33	Missing/incomplete/invalid noncovered days during the billing period.	457	Non-Covered Day(s)		
03681	Invalid Tpl Amount	125	Submission/billing error(s). 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.)	CO	Contractual Obligations			286	Other payer's Explanation of Benefits/payment information.		
03682	Occurence Span Date Is Invalid	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	N300	Missing/incomplete/invalid occurrence span date(s).	722	NUBC Occurrence Span Code Date(s)		
03683	Medicare Payment Is Required	125	Submission/billing error(s). 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.)	CO	Contractual Obligations			286	Other payer's Explanation of Benefits/payment information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03685	Invalid Or Missing Recipient Date Of Birth	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	N329	Missing/incomplete/invalid patient birth date.	158	Entity's date of birth.	QC	PATIENT
03686	The Adjustment/Void Field Is Incomplete	129	Prior processing information appears incorrect. 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.)	CO	Contractual Obligations	N152	Missing/incomplete/invalid replacement claim information.	464	Payer Assigned Claim Control Number		
03689	Undefined Claim Type	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	MA130	Your claim contains incomplete and/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.		
03700	Epidermal Autograft Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03700	Epidermal Autograft Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03701	Epidermal Autograft, Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03701	Epidermal Autograft, Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03702	Dermal Autograft, Trunk, Arms, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03702	Dermal Autograft, Trunk, Arms, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03703	Dermal Autograft, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03703	Dermal Autograft, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03704	Tissue Cultured Epidermal Autograft, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03704	Tissue Cultured Epidermal Autograft, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03705	Tissue Cultured Epidermal Autograft, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03705	Tissue Cultured Epidermal Autograft, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03706	Tissue Cultured Epidermal Autograft, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03706	Tissue Cultured Epidermal Autograft, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03707	Tissue Cultured Epidermal Autograft, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03707	Tissue Cultured Epidermal Autograft, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03708	Acellular Dermal Replacement, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03708	Acellular Dermal Replacement, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03709	Acellular Dermal Replacement, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03709	Acellular Dermal Replacement, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03710	Allograft Skin For Temporary Wound Closure, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03710	Allograft Skin For Temporary Wound Closure, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03711	Allograft Skin For Temporary Wound Closure, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03711	Allograft Skin For Temporary Wound Closure, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03712	Acellular Dermal Allograft, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03712	Acellular Dermal Allograft, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03713	Acellular Dermal Allograft, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03713	Acellular Dermal Allograft, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03714	Tissue Cultured Allogeneic Skin Substitute, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03714	Tissue Cultured Allogeneic Skin Substitute, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03715	Tissue Cultured Allogeneic Dermal Substitute, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03715	Tissue Cultured Allogeneic Dermal Substitute, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03716	Tissue Cultured Allogeneic Dermal Substitute, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03716	Tissue Cultured Allogeneic Dermal Substitute, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03717	Xenograft Skin (Dermal), For Temporary Wound Closure, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03717	Xenograft Skin (Dermal), For Temporary Wound Closure, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03718	Acellular Xenograft Implant, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03718	Acellular Xenograft Implant, Each Additional Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03719	Incision And Drainage, Open, Of Deep Abscess Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03719	Incision And Drainage, Open, Of Deep Abscess Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03719	Incision And Drainage, Open, Of Deep Abscess Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03720	Services Recouped. Incision And Drainage, Open, Of Deep Abscess Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03720	Services Recouped. Incision And Drainage, Open, Of Deep Abscess Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03720	Services Recouped. Incision And Drainage, Open, Of Deep Abscess Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03724	Resection Of Apical Lung Tumor Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03724	Resection Of Apical Lung Tumor Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03724	Resection Of Apical Lung Tumor Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03725	Services Recouped. Resection Of Apical Lung Tumor Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03725	Services Recouped. Resection Of Apical Lung Tumor Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03725	Services Recouped. Resection Of Apical Lung Tumor Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03728	Anastomosis, Cavopulmonary, Second Superior Vena Cava, Must Be Billed With Primary Procedure Code.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03728	Anastomosis, Cavopulmonary, Second Superior Vena Cava, Must Be Billed With Primary Procedure Code.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03729	Anastomosis, Cavopulmonary, Second Superior Vena Cava Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03729	Anastomosis, Cavopulmonary, Second Superior Vena Cava Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03729	Anastomosis, Cavopulmonary, Second Superior Vena Cava Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03730	Services Recouped. Anastomosis, Cavopulmonary, Second Superior Vena Cava Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03730	Services Recouped. Anastomosis, Cavopulmonary, Second Superior Vena Cava Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03730	Services Recouped. Anastomosis, Cavopulmonary, Second Superior Vena Cava Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03738	Repair Of Pulmonary Artery Arborization Anomalies Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03738	Repair Of Pulmonary Artery Arborization Anomalies Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03738	Repair Of Pulmonary Artery Arborization Anomalies Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03739	Services Recouped. Repair Of Pulmonary Artery Arborization Anomalies Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03739	Services Recouped. Repair Of Pulmonary Artery Arborization Anomalies Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03739	Services Recouped. Repair Of Pulmonary Artery Arborization Anomalies Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03740	Repair Of Pulmonary Artery Arborization Anomalies Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03740	Repair Of Pulmonary Artery Arborization Anomalies Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03740	Repair Of Pulmonary Artery Arborization Anomalies Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03741	Services Recouped. Repair Of Pulmonary Artery Arborization Anomalies Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03741	Services Recouped. Repair Of Pulmonary Artery Arborization Anomalies Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03741	Services Recouped. Repair Of Pulmonary Artery Arborization Anomalies Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03742	Contrast Injection(S) For Radiologic Evaluation Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03742	Contrast Injection(S) For Radiologic Evaluation Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03742	Contrast Injection(S) For Radiologic Evaluation Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03743	Services Recouped. Contrast Injection(S) For Radiologic Evaluation Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03743	Services Recouped. Contrast Injection(S) For Radiologic Evaluation Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03743	Services Recouped. Contrast Injection(S) For Radiologic Evaluation Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03744	Primary Percutaneous Transluminal Mechanical Thrombectomy Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03744	Primary Percutaneous Transluminal Mechanical Thrombectomy Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03744	Primary Percutaneous Transluminal Mechanical Thrombectomy Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03745	Services Recouped. Primary Percutaneous Transluminal Mechanical Thrombectomy Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03745	Services Recouped. Primary Percutaneous Transluminal Mechanical Thrombectomy Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03745	Services Recouped. Primary Percutaneous Transluminal Mechanical Thrombectomy Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03746	Related Codes Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03746	Related Codes Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03746	Related Codes Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03747	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.		
03747	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.		
03747	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.		
03748	Primary Percutaneous Transluminal Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03748	Primary Percutaneous Transluminal Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03749	Ligation, Division, And Stripping, Short Or Long Saphenous Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03749	Ligation, Division, And Stripping, Short Or Long Saphenous Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03749	Ligation, Division, And Stripping, Short Or Long Saphenous Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03750	Services Recouped. Ligation, Division, And Stripping, Short Or Long Saphenous Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03750	Services Recouped. Ligation, Division, And Stripping, Short Or Long Saphenous Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03750	Services Recouped. Ligation, Division, And Stripping, Short Or Long Saphenous Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03753	Laparascopy, Surgical Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03753	Laparascopy, Surgical Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03755	Tissue Cultured Allogeneic Skin Substitute Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03755	Tissue Cultured Allogeneic Skin Substitute Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03755	Tissue Cultured Allogeneic Skin Substitute Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03756	Services Recouped. Tissue Cultured Allogeneic Skin Substitute Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03756	Services Recouped. Tissue Cultured Allogeneic Skin Substitute Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03756	Services Recouped. Tissue Cultured Allogeneic Skin Substitute Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03757	Anorectal Exam, Surgical, Requiring Anesthesia Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03757	Anorectal Exam, Surgical, Requiring Anesthesia Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03757	Anorectal Exam, Surgical, Requiring Anesthesia Not Allowed Same Date Of Service As Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03758	Services Recouped. Anorectal Exam, Surgical, Requiring Anesthesia Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03758	Services Recouped. Anorectal Exam, Surgical, Requiring Anesthesia Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03758	Services Recouped. Anorectal Exam, Surgical, Requiring Anesthesia Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03759	Removal And Replacement Of Internally Dwelling Ureteral Not Allowed Same Date Of Service As Related Procedures.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03759	Removal And Replacement Of Internally Dwelling Ureteral Not Allowed Same Date Of Service As Related Procedures.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03759	Removal And Replacement Of Internally Dwelling Ureteral Not Allowed Same Date Of Service As Related Procedures.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03760	Services Recouped. Removal And Replacement Of Internally Dwelling Urteral Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03760	Services Recouped. Removal And Replacement Of Internally Dwelling Urteral Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03760	Services Recouped. Removal And Replacement Of Internally Dwelling Urteral Not Allowed Same Date Of Service As Related Procedures	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03761	Endometrial Sampling Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03762	Chemotherapy Administration Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03762	Chemotherapy Administration Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03765	Intravenous Infusion, Hydration Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03765	Intravenous Infusion, Hydration Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03766	Intravenous Infusion For Therapy Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03766	Intravenous Infusion For Therapy Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03767	Intravenous Infusion For Therapy Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03767	Intravenous Infusion For Therapy Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03768	Intravenous Infusion For Therapy Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03768	Intravenous Infusion For Therapy Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03769	Therapeutic, Prophylactic Or Diagnostic Injection Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03769	Therapeutic, Prophylactic Or Diagnostic Injection Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03770	Intravenous Infusion Therapies Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03770	Intravenous Infusion Therapies Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03770	Intravenous Infusion Therapies Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03771	Intravenous Infusion Therapies Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03771	Intravenous Infusion Therapies Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03771	Intravenous Infusion Therapies Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03772	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03772	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.		
03772	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.		
03773	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.		
03773	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.		
03773	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.		
03774	Stereoscopic X-Ray Guidance Not Allowed Same Date Of Service With Related Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03774	Stereoscopic X-Ray Guidance Not Allowed Same Date Of Service With Related Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03774	Stereoscopic X-Ray Guidance Not Allowed Same Date Of Service With Related Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03775	Stereoscopic X-Ray Guidance Not Allowed Same Date Of Service With Related Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03775	Stereoscopic X-Ray Guidance Not Allowed Same Date Of Service With Related Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03775	Stereoscopic X-Ray Guidance Not Allowed Same Date Of Service With Related Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03776	Evaluation Of Auditory Rehabilitation Status Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03776	Evaluation Of Auditory Rehabilitation Status Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03777	Electrical Stimulation Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
03777	Electrical Stimulation Must Be Billed With Primary Procedure Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
03778	Electrical Stimulation Not Allowed Same Date Of Service With Related Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03778	Electrical Stimulation Not Allowed Same Date Of Service With Related Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03778	Electrical Stimulation Not Allowed Same Date Of Service With Related Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03779	Services Recouped. Electrical Stimulation Not Allowed Same Date Of Service With Related Services.	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03779	Services Recouped. Electrical Stimulation Not Allowed Same Date Of Service With Related Services.	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03779	Services Recouped. Electrical Stimulation Not Allowed Same Date Of Service With Related Services.	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03780	Electrical Stimulation Not Allowed Same Date Of Service As 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.		
03780	Electrical Stimulation Not Allowed Same Date Of Service As 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.		
03780	Electrical Stimulation Not Allowed Same Date Of Service As 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.		
03781	Services Recouped. Electrical Stimulation Not Allowed Same Date Of Service As Related Services	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03781	Services Recouped. Electrical Stimulation Not Allowed Same Date Of Service As Related Services	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03781	Services Recouped. Electrical Stimulation Not Allowed Same Date Of Service As Related Services	B5	Coverage/program guidelines were not met or were exceeded.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03800	Only Six Stainless Steel Crowns Allowed On Same Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
03800	Only Six Stainless Steel Crowns Allowed On Same Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
03800	Only Six Stainless Steel Crowns Allowed On Same Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N59	Please refer to your provider manual for additional program and provider information.	259	Frequency of service.		
03800	Only Six Stainless Steel Crowns Allowed On Same Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N59	Please refer to your provider manual for additional program and provider information.	483	Maximum coverage amount met or exceeded for benefit period.		
03801	Only Six Pulpotomies Allowed On Same Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
03801	Only Six Pulpotomies Allowed On Same Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
03801	Only Six Pulpotomies Allowed On Same Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N59	Please refer to your provider manual for additional program and provider information.	259	Frequency of service.		
03801	Only Six Pulpotomies Allowed On Same Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N59	Please refer to your provider manual for additional program and provider information.	483	Maximum coverage amount met or exceeded for benefit period.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03802	Placement Of Prosthesis Requires Endovascular Repair	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	454	Procedure code for services rendered.		
03804	Transposition With Carotid Artery Repair Not Allowed Same Day As Other Transposition	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03804	Transposition With Carotid Artery Repair Not Allowed Same Day As Other Transposition	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03804	Transposition With Carotid Artery Repair Not Allowed Same Day As Other Transposition	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03809	Descending Thoracic Aorta Requires Endovascular Repair	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03810	Placement Of Prosthesis Requires Endovascular Repair	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	454	Procedure code for services rendered.		
03811	Placement Of Distal Extension Prosthesis Requires Endovascular Repair	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	454	Procedure code for services rendered.		
03812	Service Denied. Hospice Services Limited To One Unit Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
03812	Service Denied. Hospice Services Limited To One Unit Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
03812	Service Denied. Hospice Services Limited To One Unit Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	476	Missing or invalid units of service		
03813	Units Cutback. Hospice Services Limited To One Unit Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
03813	Units Cutback. Hospice Services Limited To One Unit Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
03813	Units Cutback. Hospice Services Limited To One Unit Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	476	Missing or invalid units of service		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03814	Placement Of Distal Prosthesis After Endovascular Repair Not Allowed With Related Repair Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03814	Placement Of Distal Prosthesis After Endovascular Repair Not Allowed With Related Repair Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03814	Placement Of Distal Prosthesis After Endovascular Repair Not Allowed With Related Repair Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
03815	Related Repair Procedure Not Allowed With Placement Of Distal Prosthesis After Endovascular Repair	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
03815	Related Repair Procedure Not Allowed With Placement Of Distal Prosthesis After Endovascular Repair	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
03815	Related Repair Procedure Not Allowed With Placement Of Distal Prosthesis After Endovascular Repair	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
03997	Only One Mco Capitated Payment Allowed Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04006	Dialysis Training Sessions Limited To 25 Per Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04006	Dialysis Training Sessions Limited To 25 Per Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04007	Completion Of Dialysis Training Fee Allowed Once Per Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			N117	This service is paid only once in a patient→s lifetime.	259	Frequency of service.		
04008	General Anesthesia Limited To 22 Units On Same Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.					523	Anesthesia Unit Count		
04009	Iv Sedation Limited To 22 Units On Same Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		
04010	Medicaid Has Paid The Maximum Allowable For This Equipment	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)					483	Maximum coverage amount met or exceeded for benefit period.		
04011	Tracheostomy Care Kit Limited To 90 Units Per Month For Ages (00-20)	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04012	Tracheostomy Care Kit Limited To 30 Units Per Month For Ages (21-99)	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04014	Waiver Specialized Supply-Cutback To The Maximum Of $600.00 Allowed Per Sfy	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)					483	Maximum coverage amount met or exceeded for benefit period.		
04016	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. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)					483	Maximum coverage amount met or exceeded for benefit period.		
04018	Payment Of The Appropriate Postpartum Service To This Billing Provider Is Required To Meet Medicaid Guidelines For Reimbursement Of This Code	125	Submission/billing error(s). 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.)					21	Missing or invalid information.		
04019	Refractive Code Denied Due To Medical Diagnosis/Medical Office Visit Paid In History With The Same Date Of Service. If Necessary File Adjustment To Correct Diagnosis/Procedure Code	96	Non-covered charge(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04025	Related Enhanced Benefit Services Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04025	Related Enhanced Benefit Services Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04025	Related Enhanced Benefit Services Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04025	Related Enhanced Benefit Services Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04025	Related Enhanced Benefit Services Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04025	Related Enhanced Benefit Services Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04027	Exceeds Once Per Calendar Month Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04029	Removal And Reinsertion Of Implantable Contraceptive Capsule (Norplant) Is Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04030	Second Surgery Reduced 50% If Performed On The Same Day	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					259	Frequency of service.		
04030	Second Surgery Reduced 50% If Performed On The Same Day	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04031	Radiation Treatment Delivery Limited To 3 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.		
04031	Radiation Treatment Delivery Limited To 3 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		
04035	Only Two Radiation Management Services Allowed In A 7 Day Period	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04036	Weekly Radiation Therapy Management Limited To 5 In A Four Week Period	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04038	Purchase/Rental/Repair Of Augmentative Devices Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04038	Purchase/Rental/Repair Of Augmentative Devices Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04042	Radiation Treatment Management For Cranial Lesions Not Allowed Same Day As Stereotactic Radiosurgery Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04042	Radiation Treatment Management For Cranial Lesions Not Allowed Same Day As Stereotactic Radiosurgery Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04042	Radiation Treatment Management For Cranial Lesions Not Allowed Same Day As Stereotactic Radiosurgery Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04042	Radiation Treatment Management For Cranial Lesions Not Allowed Same Day As Stereotactic Radiosurgery Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04042	Radiation Treatment Management For Cranial Lesions Not Allowed Same Day As Stereotactic Radiosurgery Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04042	Radiation Treatment Management For Cranial Lesions Not Allowed Same Day As Stereotactic Radiosurgery Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
04043	Service Recouped. Stereotactic Radiosurgery Services Not Allowed Same Day As Radiation Treatment Management For Cranial Lesions	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04043	Service Recouped. Stereotactic Radiosurgery Services Not Allowed Same Day As Radiation Treatment Management For Cranial Lesions	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
04043	Service Recouped. Stereotactic Radiosurgery Services Not Allowed Same Day As Radiation Treatment Management For Cranial Lesions	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04043	Service Recouped. Stereotactic Radiosurgery Services Not Allowed Same Day As Radiation Treatment Management For Cranial Lesions	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04043	Service Recouped. Stereotactic Radiosurgery Services Not Allowed Same Day As Radiation Treatment Management For Cranial Lesions	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04043	Service Recouped. Stereotactic Radiosurgery Services Not Allowed Same Day As Radiation Treatment Management For Cranial Lesions	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
04044	Radiation Treatment Management For Extracranial Lesions Not Same Day As Stereotactic Radiosurgery Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04044	Radiation Treatment Management For Extracranial Lesions Not Same Day As Stereotactic Radiosurgery Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
04044	Radiation Treatment Management For Extracranial Lesions Not Same Day As Stereotactic Radiosurgery Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04044	Radiation Treatment Management For Extracranial Lesions Not Same Day As Stereotactic Radiosurgery Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04044	Radiation Treatment Management For Extracranial Lesions Not Same Day As Stereotactic Radiosurgery Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04044	Radiation Treatment Management For Extracranial Lesions Not Same Day As Stereotactic Radiosurgery Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04045	Service Recouped. Stereotactic Radiosurgery Services Not Allowed Same Day As Radiation Treatment Management For Extracranial Lesions	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04045	Service Recouped. Stereotactic Radiosurgery Services Not Allowed Same Day As Radiation Treatment Management For Extracranial Lesions	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
04045	Service Recouped. Stereotactic Radiosurgery Services Not Allowed Same Day As Radiation Treatment Management For Extracranial Lesions	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04045	Service Recouped. Stereotactic Radiosurgery Services Not Allowed Same Day As Radiation Treatment Management For Extracranial Lesions	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04045	Service Recouped. Stereotactic Radiosurgery Services Not Allowed Same Day As Radiation Treatment Management For Extracranial Lesions	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04045	Service Recouped. Stereotactic Radiosurgery Services Not Allowed Same Day As Radiation Treatment Management For Extracranial Lesions	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
04046	Radiation Management Is Limited To Twice In A 7 Day Period	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04046	Radiation Management Is Limited To Twice In A 7 Day Period	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04049	Intranasal And H1N1 Vaccine Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04049	Intranasal And H1N1 Vaccine Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
04049	Intranasal And H1N1 Vaccine Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04049	Intranasal And H1N1 Vaccine Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04086	Procedure Billed With This Modifier Only Allows Two Units. Units Have Been Exceeded For This Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04091	Related Vaccines Are Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
04091	Related Vaccines Are Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04091	Related Vaccines Are Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
04091	Related Vaccines Are Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04095	Only One Sleep Study Procedure Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04095	Only One Sleep Study Procedure Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04096	One Multiple Extremity Electromyography Procedure Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04096	One Multiple Extremity Electromyography Procedure Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04097	One Home Visit Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04097	One Home Visit Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04100	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). 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.)			M50	Missing/incomplete/invalid revenue code(s).	454	Procedure code for services rendered.		
04100	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). 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.)			M50	Missing/incomplete/invalid revenue code(s).	455	Revenue code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04100	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). 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.)			M51	Missing/incomplete/invalid procedure code(s).	454	Procedure code for services rendered.		
04100	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). 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.)			M51	Missing/incomplete/invalid procedure code(s).	455	Revenue code for services rendered.		
04102	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). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	1	For more detailed information, see remittance advice.		
04102	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). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	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 re-submit.		
04102	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). 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.)			N152	Missing/incomplete/invalid replacement claim information.	1	For more detailed information, see remittance advice.		
04102	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). 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.)			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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04103	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). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	1	For more detailed information, see remittance advice.		
04103	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). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	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 re-submit.		
04103	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). 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.)			N152	Missing/incomplete/invalid replacement claim information.	1	For more detailed information, see remittance advice.		
04103	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). 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.)			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		
04104	The Number Of Ach Facilty Beds Is Not Listed On The Provide File For Provider Taxonomy	125	Submission/billing error(s). 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.)			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.		
04104	The Number Of Ach Facilty Beds Is Not Listed On The Provide File For Provider Taxonomy	125	Submission/billing error(s). 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.)			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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04116	Suspect Duplicate, Same Procedure Code/Rendering Provider And Overlapping Dos	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04120	Units Cutback. Maximum Number Of Units Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
04120	Units Cutback. Maximum Number Of Units Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04120	Units Cutback. Maximum Number Of Units Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04120	Units Cutback. Maximum Number Of Units Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04124	Rental Cost Exceeds Purchase Price For 1 Year, Ages 021-115	108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.	186	Purchase and rental price of durable medical equipment.		
04152	Delivery Only Or Related Abdominal Surgery Not Allowed Same Day As Delivery With Postpartum Care By Same Rendering Provider	125	Submission/billing error(s). 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.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04153	Delivery With Postpartum Care Performed This Day By Same Rendering Provider. Delivery Only Or Related Abdominal Surgery Recouped	125	Submission/billing error(s). 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.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04200	Allow One Topical Fluoride Varnish Application Every 60 Days	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04201	Incision Procedure Is A Component Of Surgical Procedure Already Paid For This Date Of Service. No Payment Allowed For Current Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	187	Date(s) of service.		
04201	Incision Procedure Is A Component Of Surgical Procedure Already Paid For This Date Of Service. No Payment Allowed For Current Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04201	Incision Procedure Is A Component Of Surgical Procedure Already Paid For This Date Of Service. No Payment Allowed For Current Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04201	Incision Procedure Is A Component Of Surgical Procedure Already Paid For This Date Of Service. No Payment Allowed For Current Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04202	Surgical Procedure Does Not Allow Separate Incision Component On Same Day. Component Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	187	Date(s) of service.		
04202	Surgical Procedure Does Not Allow Separate Incision Component On Same Day. Component Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04202	Surgical Procedure Does Not Allow Separate Incision Component On Same Day. Component Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04202	Surgical Procedure Does Not Allow Separate Incision Component On Same Day. Component Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04213	Exceeds 60 Procedures Per Day Limitation	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04213	Exceeds 60 Procedures Per Day Limitation	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04214	Exceeds 20 Procedures Per Day Limitation	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04214	Exceeds 20 Procedures Per Day Limitation	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04219	Thromboendarterectomy And Harvest Of Upper Extremity Vein Are Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04219	Thromboendarterectomy And Harvest Of Upper Extremity Vein Are Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04219	Thromboendarterectomy And Harvest Of Upper Extremity Vein Are Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04219	Thromboendarterectomy And Harvest Of Upper Extremity Vein Are Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04221	Related Bypass Procedures Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04221	Related Bypass Procedures Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04221	Related Bypass Procedures Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04221	Related Bypass Procedures Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04229	Claim Denied. Ultrasound Of Transplanted Kidney Not Allowed Same Day As Visceral And Penile Vascular Studies	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04229	Claim Denied. Ultrasound Of Transplanted Kidney Not Allowed Same Day As Visceral And Penile Vascular Studies	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04229	Claim Denied. Ultrasound Of Transplanted Kidney Not Allowed Same Day As Visceral And Penile Vascular Studies	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04229	Claim Denied. Ultrasound Of Transplanted Kidney Not Allowed Same Day As Visceral And Penile Vascular Studies	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04230	Claim Recouped. Ultrasound Of Transplanted Kidney Not Allowed Same Day As Visceral And Penile Vascular Studies					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04230	Claim Recouped. Ultrasound Of Transplanted Kidney Not Allowed Same Day As Visceral And Penile Vascular Studies					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		
04230	Claim Recouped. Ultrasound Of Transplanted Kidney Not Allowed Same Day As Visceral And Penile Vascular Studies					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04230	Claim Recouped. Ultrasound Of Transplanted Kidney Not Allowed Same Day As Visceral And Penile Vascular Studies					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04231	Claim Denied. Ultrasonic Guidance, Intraoperative Not Allowed Same Day As Laparoscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04231	Claim Denied. Ultrasonic Guidance, Intraoperative Not Allowed Same Day As Laparoscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04231	Claim Denied. Ultrasonic Guidance, Intraoperative Not Allowed Same Day As Laparoscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04231	Claim Denied. Ultrasonic Guidance, Intraoperative Not Allowed Same Day As Laparoscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04232	Claim Recouped. Ultrasonic Guidance, Intraoperative Not Allowed Same Day As Laparoscopy	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04232	Claim Recouped. Ultrasonic Guidance, Intraoperative Not Allowed Same Day As Laparoscopy	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04232	Claim Recouped. Ultrasonic Guidance, Intraoperative Not Allowed Same Day As Laparoscopy	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04232	Claim Recouped. Ultrasonic Guidance, Intraoperative Not Allowed Same Day As Laparoscopy	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04233	Related Fluoroscopic Guidance Procedures Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04233	Related Fluoroscopic Guidance Procedures Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04233	Related Fluoroscopic Guidance Procedures Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04233	Related Fluoroscopic Guidance Procedures Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04234	Claim Recouped. Related Fluoroscopic Guidance Procedures Not Allowed On The Same Date Of Service					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04234	Claim Recouped. Related Fluoroscopic Guidance Procedures Not Allowed On The Same Date Of Service					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		
04234	Claim Recouped. Related Fluoroscopic Guidance Procedures Not Allowed On The Same Date Of Service					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04234	Claim Recouped. Related Fluoroscopic Guidance Procedures Not Allowed On The Same Date Of Service					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04235	Claim Denied. Fluoroscopic Guidance For Needle Placement Not Allowed Same Day As Radiological Examination	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04235	Claim Denied. Fluoroscopic Guidance For Needle Placement Not Allowed Same Day As Radiological Examination	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04235	Claim Denied. Fluoroscopic Guidance For Needle Placement Not Allowed Same Day As Radiological Examination	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04235	Claim Denied. Fluoroscopic Guidance For Needle Placement Not Allowed Same Day As Radiological Examination	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04236	Claim Recouped. Fluoroscopic Guidance For Needle Placement Not Allowed Same Day As Radiological Examination					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04236	Claim Recouped. Fluoroscopic Guidance For Needle Placement Not Allowed Same Day As Radiological Examination					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		
04236	Claim Recouped. Fluoroscopic Guidance For Needle Placement Not Allowed Same Day As Radiological Examination					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04236	Claim Recouped. Fluoroscopic Guidance For Needle Placement Not Allowed Same Day As Radiological Examination					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04237	Claim Denied. Fluoroscopic Guidance Not Allowed Same Day As Surgical Or Radiological Procedures	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04237	Claim Denied. Fluoroscopic Guidance Not Allowed Same Day As Surgical Or Radiological Procedures	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04237	Claim Denied. Fluoroscopic Guidance Not Allowed Same Day As Surgical Or Radiological Procedures	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04237	Claim Denied. Fluoroscopic Guidance Not Allowed Same Day As Surgical Or Radiological Procedures	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04238	Claim Recouped. Fluoroscopic Guidance Not Allowed Same Day As Surgical Or Radiological Procedures					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04238	Claim Recouped. Fluoroscopic Guidance Not Allowed Same Day As Surgical Or Radiological Procedures					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		
04238	Claim Recouped. Fluoroscopic Guidance Not Allowed Same Day As Surgical Or Radiological Procedures					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04238	Claim Recouped. Fluoroscopic Guidance Not Allowed Same Day As Surgical Or Radiological Procedures					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04239	Claim Denied. Fluoroscopic Guidance Not Allowed Same Day As Myelography Procedures	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04239	Claim Denied. Fluoroscopic Guidance Not Allowed Same Day As Myelography Procedures	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04239	Claim Denied. Fluoroscopic Guidance Not Allowed Same Day As Myelography Procedures	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04239	Claim Denied. Fluoroscopic Guidance Not Allowed Same Day As Myelography Procedures	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04241	Claim Denied. Computerized Tomography Guidance Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04241	Claim Denied. Computerized Tomography Guidance Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04241	Claim Denied. Computerized Tomography Guidance Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04241	Claim Denied. Computerized Tomography Guidance Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04242	Claim Recouped. Computerized Tomography Guidance Previously Paid	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04243	Claim Denied. Laparoscopy/Hysteroscopy Not Allowed Same Day As Related Surgery	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04243	Claim Denied. Laparoscopy/Hysteroscopy Not Allowed Same Day As Related Surgery	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04243	Claim Denied. Laparoscopy/Hysteroscopy Not Allowed Same Day As Related Surgery	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04243	Claim Denied. Laparoscopy/Hysteroscopy Not Allowed Same Day As Related Surgery	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04244	Claim Recouped. Laparoscopy/Hysteroscopy Not Allowed Same Day As Related Surgery	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04244	Claim Recouped. Laparoscopy/Hysteroscopy Not Allowed Same Day As Related Surgery	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04244	Claim Recouped. Laparoscopy/Hysteroscopy Not Allowed Same Day As Related Surgery	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04244	Claim Recouped. Laparoscopy/Hysteroscopy Not Allowed Same Day As Related Surgery	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04245	Claim Denied. Abdominal Laparoscopy Not Allowed Same Day As Laparoscopy/Hysteroscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04245	Claim Denied. Abdominal Laparoscopy Not Allowed Same Day As Laparoscopy/Hysteroscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04245	Claim Denied. Abdominal Laparoscopy Not Allowed Same Day As Laparoscopy/Hysteroscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04245	Claim Denied. Abdominal Laparoscopy Not Allowed Same Day As Laparoscopy/Hysteroscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04246	Claim Recouped. Abdominal Laparoscopy Not Allowed Same Day As Laparoscopy/Hysteroscopy	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04246	Claim Recouped. Abdominal Laparoscopy Not Allowed Same Day As Laparoscopy/Hysteroscopy	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04246	Claim Recouped. Abdominal Laparoscopy Not Allowed Same Day As Laparoscopy/Hysteroscopy	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04246	Claim Recouped. Abdominal Laparoscopy Not Allowed Same Day As Laparoscopy/Hysteroscopy	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04247	Claim Denied. Surgical Laparoscopy Not Allowed Same Day As Laparoscopy With Radical Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04247	Claim Denied. Surgical Laparoscopy Not Allowed Same Day As Laparoscopy With Radical Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04247	Claim Denied. Surgical Laparoscopy Not Allowed Same Day As Laparoscopy With Radical Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04247	Claim Denied. Surgical Laparoscopy Not Allowed Same Day As Laparoscopy With Radical Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04248	Claim Recouped. Surgical Laparoscopy Not Allowed Same Day As Laparoscopy With Radical Hysterectomy	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04248	Claim Recouped. Surgical Laparoscopy Not Allowed Same Day As Laparoscopy With Radical Hysterectomy	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04248	Claim Recouped. Surgical Laparoscopy Not Allowed Same Day As Laparoscopy With Radical Hysterectomy	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04248	Claim Recouped. Surgical Laparoscopy Not Allowed Same Day As Laparoscopy With Radical Hysterectomy	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04249	Claim Denied. Related Surgical Procedures Not Allowed Same Day As Resection (Tumor Debulking)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04249	Claim Denied. Related Surgical Procedures Not Allowed Same Day As Resection (Tumor Debulking)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04249	Claim Denied. Related Surgical Procedures Not Allowed Same Day As Resection (Tumor Debulking)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04249	Claim Denied. Related Surgical Procedures Not Allowed Same Day As Resection (Tumor Debulking)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04251											
04252								228	Type of bill for UB claim		
04253								228	Type of bill for UB claim		
04254											
04255	Drg - Other Diagnosis Code 10 Is Invalid Or Requires Further Subdivision. Correct And Resubmit Claim	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	M64	Missing/incomplete/invalid other diagnosis.	255	Diagnosis code.		
04256	Drg - Other Diagnosis Code Found In 11 Through 17 Is Invalid Or Requires Further Subdivision. Correct And Resubmit Claim	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	M64	Missing/incomplete/invalid other diagnosis.	255	Diagnosis code.		
04257	Drg - Other Diagnosis Code Found In 18 Through 25 Is Invalid Or Requires Further Subdivision. Correct And Resubmit Claim	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	M64	Missing/incomplete/invalid other diagnosis.	255	Diagnosis code.		
04258	Claim Denied. Physician Supervision Of Patients Under Care Of Home Health Not Allowed Within 30 Days Of Pediatric Home Apnea Monitoring Event	A1	Claim/Service denied. 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.)					454	Procedure code for services rendered.		
04259	Claim Recouped. Physician Supervision Of Patients Under Care Of Home Health Not Allowed Within 30 Days Of Pediatric Home Apnea Monitoring Event							454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04263	Procedure/Modifier Limited To 2 Units Per Day. If Additional Units Were Provided Rebill As Adjustment With Medical Records	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N362	The number of Days or Units of Service exceeds our acceptable maximum.	294	Supporting documentation.		
04263	Procedure/Modifier Limited To 2 Units Per Day. If Additional Units Were Provided Rebill As Adjustment With Medical Records	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N362	The number of Days or Units of Service exceeds our acceptable maximum.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04263	Procedure/Modifier Limited To 2 Units Per Day. If Additional Units Were Provided Rebill As Adjustment With Medical Records	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
04264	Procedure Limited To 1 Unit Without Modifier. If Multiple Units Were Provided, Resubmit Claim With Appropriate Modifiers	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M53	Missing/incomplete/invalid days or units of service.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04265	Exceeds 3 Units Per Day Limitation	B5	Coverage/program guidelines were not met or were exceeded.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04265	Exceeds 3 Units Per Day Limitation	B5	Coverage/program guidelines were not met or were exceeded.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
04265	Exceeds 3 Units Per Day Limitation	B5	Coverage/program guidelines were not met or were exceeded.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04265	Exceeds 3 Units Per Day Limitation	B5	Coverage/program guidelines were not met or were exceeded.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04265	Exceeds 3 Units Per Day Limitation	B5	Coverage/program guidelines were not met or were exceeded.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04265	Exceeds 3 Units Per Day Limitation	B5	Coverage/program guidelines were not met or were exceeded.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
04267	Exceeds 4 Units Per 31 Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04267	Exceeds 4 Units Per 31 Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
04267	Exceeds 4 Units Per 31 Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04267	Exceeds 4 Units Per 31 Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
04269	Orthotic Or Prosthetic Equipment Allowed Once Every 18 Months For Ages 000 - 005. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N129	Not eligible due to the patient's age.	258	Days/units for procedure/revenue code.		
04269	Orthotic Or Prosthetic Equipment Allowed Once Every 18 Months For Ages 000 - 005. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N129	Not eligible due to the patient's age.	259	Frequency of service.		
04270	Related Cardiovascular Surgeries Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04270	Related Cardiovascular Surgeries Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04270	Related Cardiovascular Surgeries Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04270	Related Cardiovascular Surgeries Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04271	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04271	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04271	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
04272	Inhalation Treatment, First Hour Once Per Day	B5	Coverage/program guidelines were not met or were exceeded.			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04272	Inhalation Treatment, First Hour Once Per Day	B5	Coverage/program guidelines were not met or were exceeded.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04272	Inhalation Treatment, First Hour Once Per Day	B5	Coverage/program guidelines were not met or were exceeded.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04273	Related Pulmonary Procedures Not Allowed Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04273	Related Pulmonary Procedures Not Allowed Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04273	Related Pulmonary Procedures Not Allowed Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04273	Related Pulmonary Procedures Not Allowed Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04274	Related Pulmonary Procedures Not Allowed Same Date Of Service					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04274	Related Pulmonary Procedures Not Allowed Same Date Of Service					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		
04274	Related Pulmonary Procedures Not Allowed Same Date Of Service					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04274	Related Pulmonary Procedures Not Allowed Same Date Of Service					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04275	Catheterization Not Allowed Same Day As Comprehensive Surgical Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04275	Catheterization Not Allowed Same Day As Comprehensive Surgical Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04275	Catheterization Not Allowed Same Day As Comprehensive Surgical Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04275	Catheterization Not Allowed Same Day As Comprehensive Surgical Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04276	Comprehensive Surgical Procedure Not Allowed Same Day As Related Catheterization. Catheterization Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04276	Comprehensive Surgical Procedure Not Allowed Same Day As Related Catheterization. Catheterization Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04276	Comprehensive Surgical Procedure Not Allowed Same Day As Related Catheterization. Catheterization Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04276	Comprehensive Surgical Procedure Not Allowed Same Day As Related Catheterization. Catheterization Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04277	Delayed Creation Of Exit Site Not Allowed Same Day As Insertion Of Intraperitoneal Cannula Or Catheter	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04277	Delayed Creation Of Exit Site Not Allowed Same Day As Insertion Of Intraperitoneal Cannula Or Catheter	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04277	Delayed Creation Of Exit Site Not Allowed Same Day As Insertion Of Intraperitoneal Cannula Or Catheter	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04277	Delayed Creation Of Exit Site Not Allowed Same Day As Insertion Of Intraperitoneal Cannula Or Catheter	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04278	Insertion Procedure Not Allowed Same Day As Related Procedure. Delayed Creation Of Exit Site Procedure Recouped					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04278	Insertion Procedure Not Allowed Same Day As Related Procedure. Delayed Creation Of Exit Site Procedure Recouped					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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04278	Insertion Procedure Not Allowed Same Day As Related Procedure. Delayed Creation Of Exit Site Procedure Recouped					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04278	Insertion Procedure Not Allowed Same Day As Related Procedure. Delayed Creation Of Exit Site Procedure Recouped					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04279	Related Treatment Procedure Not Allowed Same Day As Stereotactic Radiation Treatments	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04279	Related Treatment Procedure Not Allowed Same Day As Stereotactic Radiation Treatments	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04279	Related Treatment Procedure Not Allowed Same Day As Stereotactic Radiation Treatments	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04279	Related Treatment Procedure Not Allowed Same Day As Stereotactic Radiation Treatments	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04280	Stereotactic Radiation Treatment Not Allowed Same Day As Related Treatment Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04280	Stereotactic Radiation Treatment Not Allowed Same Day As Related Treatment Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04280	Stereotactic Radiation Treatment Not Allowed Same Day As Related Treatment Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04280	Stereotactic Radiation Treatment Not Allowed Same Day As Related Treatment Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04281	Radiation Management Not Allowed Same Date Of Service As Radiation Therapy					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04281	Radiation Management Not Allowed Same Date Of Service As Radiation Therapy					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		
04281	Radiation Management Not Allowed Same Date Of Service As Radiation Therapy					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04281	Radiation Management Not Allowed Same Date Of Service As Radiation Therapy					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04282	Radiation Therapy Not Allowed Same Date Of Service As Radiation Management	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04282	Radiation Therapy Not Allowed Same Date Of Service As Radiation Management	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04282	Radiation Therapy Not Allowed Same Date Of Service As Radiation Management	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04282	Radiation Therapy Not Allowed Same Date Of Service As Radiation Management	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04285	Cardiovascular Graft Procedure Not Allowed Same Day As Related Cardiovascular Surgery Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04285	Cardiovascular Graft Procedure Not Allowed Same Day As Related Cardiovascular Surgery Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04285	Cardiovascular Graft Procedure Not Allowed Same Day As Related Cardiovascular Surgery Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04285	Cardiovascular Graft Procedure Not Allowed Same Day As Related Cardiovascular Surgery Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04285	Cardiovascular Graft Procedure Not Allowed Same Day As Related Cardiovascular Surgery Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04285	Cardiovascular Graft Procedure Not Allowed Same Day As Related Cardiovascular Surgery Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04286	Cardiovascular Surgery Procedure Not Allowed Same Day As Related Cardiovascular Graft. Graft Procedure Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04286	Cardiovascular Surgery Procedure Not Allowed Same Day As Related Cardiovascular Graft. Graft Procedure Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04286	Cardiovascular Surgery Procedure Not Allowed Same Day As Related Cardiovascular Graft. Graft Procedure Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04286	Cardiovascular Surgery Procedure Not Allowed Same Day As Related Cardiovascular Graft. Graft Procedure Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04286	Cardiovascular Surgery Procedure Not Allowed Same Day As Related Cardiovascular Graft. Graft Procedure Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04286	Cardiovascular Surgery Procedure Not Allowed Same Day As Related Cardiovascular Graft. Graft Procedure Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04288	Insertion Procedure Not Allowed Same Date Of Service As Repair Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04288	Insertion Procedure Not Allowed Same Date Of Service As Repair Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04288	Insertion Procedure Not Allowed Same Date Of Service As Repair Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04288	Insertion Procedure Not Allowed Same Date Of Service As Repair Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04289	Repair Procedure Not Allowed Same Date Of Service As Related Insertion Procedure. Insertion Procedure Recouped	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.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04289	Repair Procedure Not Allowed Same Date Of Service As Related Insertion Procedure. Insertion Procedure Recouped	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.			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		
04289	Repair Procedure Not Allowed Same Date Of Service As Related Insertion Procedure. Insertion Procedure Recouped	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.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04289	Repair Procedure Not Allowed Same Date Of Service As Related Insertion Procedure. Insertion Procedure Recouped	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.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04290	Component Of Surgical Incision/Closure Procedure Not Allowed On Same Date Of Service As A Related Closure Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04290	Component Of Surgical Incision/Closure Procedure Not Allowed On Same Date Of Service As A Related Closure Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
04290	Component Of Surgical Incision/Closure Procedure Not Allowed On Same Date Of Service As A Related Closure Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04290	Component Of Surgical Incision/Closure Procedure Not Allowed On Same Date Of Service As A Related Closure Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04290	Component Of Surgical Incision/Closure Procedure Not Allowed On Same Date Of Service As A Related Closure Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04290	Component Of Surgical Incision/Closure Procedure Not Allowed On Same Date Of Service As A Related Closure Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04291	Related Closure Procedure Not Allowed Same Day As Component Incision/Closure Procedure. Component Incision/Closure Procedure Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04291	Related Closure Procedure Not Allowed Same Day As Component Incision/Closure Procedure. Component Incision/Closure Procedure Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
04291	Related Closure Procedure Not Allowed Same Day As Component Incision/Closure Procedure. Component Incision/Closure Procedure Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04291	Related Closure Procedure Not Allowed Same Day As Component Incision/Closure Procedure. Component Incision/Closure Procedure Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04291	Related Closure Procedure Not Allowed Same Day As Component Incision/Closure Procedure. Component Incision/Closure Procedure Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04291	Related Closure Procedure Not Allowed Same Day As Component Incision/Closure Procedure. Component Incision/Closure Procedure Recouped	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04292	Surgical Procedure Not Allowed Same Day As Separate Scopy Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	187	Date(s) of service.		
04292	Surgical Procedure Not Allowed Same Day As Separate Scopy Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04292	Surgical Procedure Not Allowed Same Day As Separate Scopy Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04292	Surgical Procedure Not Allowed Same Day As Separate Scopy Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04292	Surgical Procedure Not Allowed Same Day As Separate Scopy Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04292	Surgical Procedure Not Allowed Same Day As Separate Scopy Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04293	Separate Scopy Procedure Not Allowed Same Day As Surgical Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	187	Date(s) of service.		
04293	Separate Scopy Procedure Not Allowed Same Day As Surgical Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04293	Separate Scopy Procedure Not Allowed Same Day As Surgical Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04293	Separate Scopy Procedure Not Allowed Same Day As Surgical Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04293	Separate Scopy Procedure Not Allowed Same Day As Surgical Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04293	Separate Scopy Procedure Not Allowed Same Day As Surgical Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04294	Repair Procedures Not Allowed Same Day As Excision Of Skin	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04294	Repair Procedures Not Allowed Same Day As Excision Of Skin	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04294	Repair Procedures Not Allowed Same Day As Excision Of Skin	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04294	Repair Procedures Not Allowed Same Day As Excision Of Skin	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04295	Excision Of Skin Not Allowed Same Day As Repair Procedures					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04295	Excision Of Skin Not Allowed Same Day As Repair Procedures					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		
04295	Excision Of Skin Not Allowed Same Day As Repair Procedures					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04295	Excision Of Skin Not Allowed Same Day As Repair Procedures					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04296	Corneal Topography Not Allowed Same Day As Keratoplasty	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04296	Corneal Topography Not Allowed Same Day As Keratoplasty	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04296	Corneal Topography Not Allowed Same Day As Keratoplasty	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04296	Corneal Topography Not Allowed Same Day As Keratoplasty	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04297	Corneal Topography Recouped. Service Not Allowed Same Day As Keratoplasty					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04297	Corneal Topography Recouped. Service Not Allowed Same Day As Keratoplasty					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		
04297	Corneal Topography Recouped. Service Not Allowed Same Day As Keratoplasty					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04297	Corneal Topography Recouped. Service Not Allowed Same Day As Keratoplasty					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04300	Dme Iou Limited Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04300	Dme Iou Limited Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04301	Denied - Dme Iou Limited Per 6 Calendar Months	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04301	Denied - Dme Iou Limited Per 6 Calendar Months	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04302	Dme Iou Limited Ounces Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04302	Dme Iou Limited Ounces Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04303	Denied - Dme Iou Limited Ounces Per 6 Calendar Months	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04303	Denied - Dme Iou Limited Ounces Per 6 Calendar Months	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04304	Dme Iou Limited Tablets Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04304	Dme Iou Limited Tablets Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04305	Dme Iou Limitation Of 150 Per 6 Calendar Months Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04305	Dme Iou Limitation Of 150 Per 6 Calendar Months Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04306	Dme Iou Limitation Of 2 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04306	Dme Iou Limitation Of 2 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04307	Dme Iou Limitation Of 3 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04307	Dme Iou Limitation Of 3 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04308	Dme Iou Limitation Of 4 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04308	Dme Iou Limitation Of 4 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04309	Dme Iou Limitation Of 10 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04309	Dme Iou Limitation Of 10 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04310	Dme Iou Limitation Of 15 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04310	Dme Iou Limitation Of 15 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04311	Dme Iou Limitation Of 20 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04311	Dme Iou Limitation Of 20 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04312	Dme Iou Limitation Of 31 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04312	Dme Iou Limitation Of 31 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04313	Dme Iou Limitation Of 35 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04313	Dme Iou Limitation Of 35 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04314	Dme Iou Limitation Of 60 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04314	Dme Iou Limitation Of 60 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04315	Dme Iou Limitation Of 80 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04315	Dme Iou Limitation Of 80 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04316	Dme Iou Limitation Of 192 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04316	Dme Iou Limitation Of 192 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04317	Dme Iou Limitation Of 200 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04317	Dme Iou Limitation Of 200 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04318	Dme Incontinence Ostomy Urinary (Iou) Supply Limitation Of 1 Box Of 50 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04318	Dme Incontinence Ostomy Urinary (Iou) Supply Limitation Of 1 Box Of 50 Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04319	Dme Incontinence Ostomy Urinary (Iou) Supply Limitation Of 2 Per 6 Calendar Months Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04319	Dme Incontinence Ostomy Urinary (Iou) Supply Limitation Of 2 Per 6 Calendar Months Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04320	Dme Incontinence Ostomy Urinary (Iou) Supply Limitation Of 4 Ounces Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04320	Dme Incontinence Ostomy Urinary (Iou) Supply Limitation Of 4 Ounces Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04321	Dme Inconience Ostomy Urinary (Iou) Supply Limitation Of 16 Ounces Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04321	Dme Inconience Ostomy Urinary (Iou) Supply Limitation Of 16 Ounces Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04322	Dme Iou Limitation Of 3 Per 6 Calendar Months Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04322	Dme Iou Limitation Of 3 Per 6 Calendar Months Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04323	Dme Iou Limitation Of One Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04323	Dme Iou Limitation Of One Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04324	Dme Iou Limitation Of 2 Ounces Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04324	Dme Iou Limitation Of 2 Ounces Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04325	Dme Iou Limitation Of 1 (16 Oz) Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04325	Dme Iou Limitation Of 1 (16 Oz) Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04326	Dme Iou Limitation Of 100 Tablets Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04326	Dme Iou Limitation Of 100 Tablets Per Calendar Month Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04327	Dme Iou Limitation Of 16 Ounces Per 6 Calendar Months Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04327	Dme Iou Limitation Of 16 Ounces Per 6 Calendar Months Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04365	Service Denied. Exceeds 1 Per 365 Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04365	Service Denied. Exceeds 1 Per 365 Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	259	Frequency of service.		
04366	Units Cutback To Allow 1 Unit Per 365 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04366	Units Cutback To Allow 1 Unit Per 365 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04366	Units Cutback To Allow 1 Unit Per 365 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	476	Missing or invalid units of service		
04368	Service Denied. Exceeds The Limitation Of Units Allowed Per 28 Days	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04368	Service Denied. Exceeds The Limitation Of Units Allowed Per 28 Days	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04369	Units Cutback To The Maximum Units Allowed	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04370	Service Denied. Exceeds The Limitation Of Units Allowed Per Calendar Month	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04370	Service Denied. Exceeds The Limitation Of Units Allowed Per Calendar Month	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04371	Orthotic Or Prosthetic Equipment Allowed Six Per Year For Ages 000-002. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N129	Not eligible due to the patient's age.	258	Days/units for procedure/revenue code.		
04371	Orthotic Or Prosthetic Equipment Allowed Six Per Year For Ages 000-002. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N129	Not eligible due to the patient's age.	259	Frequency of service.		
04372	Drug Units Cutback To The Allowable 85 Units Per 28 Days	119	Benefit maximum for this time period or occurrence has been reached.			M53	Missing/incomplete/invalid days or units of service.	258	Days/units for procedure/revenue code.		
04372	Drug Units Cutback To The Allowable 85 Units Per 28 Days	119	Benefit maximum for this time period or occurrence has been reached.			M53	Missing/incomplete/invalid days or units of service.	259	Frequency of service.		
04372	Drug Units Cutback To The Allowable 85 Units Per 28 Days	119	Benefit maximum for this time period or occurrence has been reached.			M53	Missing/incomplete/invalid days or units of service.	476	Missing or invalid units of service		
04372	Drug Units Cutback To The Allowable 85 Units Per 28 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.		
04372	Drug Units Cutback To The Allowable 85 Units Per 28 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.		
04372	Drug Units Cutback To The Allowable 85 Units Per 28 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.	476	Missing or invalid units of service		
04373	Drug Units Cutback To The Allowable 210 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M53	Missing/incomplete/invalid days or units of service.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04373	Drug Units Cutback To The Allowable 210 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M53	Missing/incomplete/invalid days or units of service.	259	Frequency of service.		
04373	Drug Units Cutback To The Allowable 210 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M53	Missing/incomplete/invalid days or units of service.	476	Missing or invalid units of service		
04373	Drug Units Cutback To The Allowable 210 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.		
04373	Drug Units Cutback To The Allowable 210 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.		
04373	Drug Units Cutback To The Allowable 210 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.	476	Missing or invalid units of service		
04416	Personal Care Services Not Allowed On Same Or Overlapping Dos As Inpatient Or Nursing Home Stay	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
04417	Duplicate Claim Submission - Different Billing Provider Number, Same Gcn, Patient, And Date Of Service	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04418	Dme Procedure Allowed Once Per Year	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		
04420	Exact Duplicate-Same Procedure/Rendering Provider And Overlapping Dos, Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04423	Suspect Duplicate-Overlapping Dos, Same Procedure/Blank Modifiers Spaces. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04424	Suspect Duplicate-Overlapping Dos, Same Procedure/Anesthia Modifiers. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04425	Suspect Duplicate-Overlapping Dos, Same Procedure/Assistant Surgeon Modifiers. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04426	Suspect Duplicate-Overlapping Dos, Same Procedure/Primary Service Modifiers. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04427	Suspect Duplicate- Overlapping Dos, Same Procedure/Ambulance Modifiers. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04428	Suspect Duplicate- Overlapping Dos, Same Procedure/Professional And Technical Modifiers. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04429	Suspect Duplicate- Overlapping Dos, Same Procedure/Ambulatory Surgery Center Modifier. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04430	Suspect Duplicate- Overlapping Dos, Same Procedure/Durable Medical Equipment Or Home Insusion Therapy Modifiers. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04431	Suspect Duplicate- Overlapping Dos, Same Procedures/ Related Eye Modifiers. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04432	Suspect Duplicate- Overlapping Dos, Same Procedure/ Related Finger Modifiers. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04433	Suspect Duplicate- Overlapping Dos, Same Procedure/ Related Toe Modifiers. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04434	Suspect Duplicate- Overlapping Dos, Same Procedure/Bilateral Procedure Modifiers. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04435	Duplicate Billing. Matching Crossover Claim Recouped. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			N20	Service not payable with other service rendered on the same date.	54	Duplicate of a previously processed claim/line.		
04437	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.		
04439	Suspect Duplicate- Overlapping Dos, Same Procedure, Different Modfiers. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04440	Suspect Duplicate- Overlapping Dos, Same Procedure, Different Modifiers. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04441	Suspect Duplicate- Overlapping Dos, Same Procedure, Different Modifiers. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04442	Suspect Duplicate-Overlapping Dos, Same Procedure, Different Modifiers. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04443	Suspect Duplicate- Overlapping Dos, Same Procedure, Different Modifiers. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04444	Suspect Duplicate- Overlapping Dos, Same Procedure, Different Modifiers. Professional	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04445	Service Not Allowed While Recipient Is Enrolled In A High Risk Intervention-Residental Hospital	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
04446	Service Recouped. Recipient Is Enrolled In A High Risk Intervention-Residential Hospital On The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
04450	Claim Denied. Exact Duplicate Of Previously Paid Claim With The Same Medicare Tcn	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
04465	Personal Care Services Are Not Allowed When Recipient Is Receiving Inpatient Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M2	Not paid separately when the patient is an inpatient.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04466	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.		
04470	Orthotic Or Prosthetic Equipment Allowed Once Per Three Years For Ages 006 - 115. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N129	Not eligible due to the patient's age.	258	Days/units for procedure/revenue code.		
04470	Orthotic Or Prosthetic Equipment Allowed Once Per Three Years For Ages 006 - 115. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N129	Not eligible due to the patient's age.	259	Frequency of service.		
04472	Exceeds 10 Units Per 270 Day Limitation	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04472	Exceeds 10 Units Per 270 Day Limitation	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04473	Anesthesia Procedure Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04473	Anesthesia Procedure Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04473	Anesthesia Procedure Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N203	Missing/incomplete/invalid anesthesia time/units	259	Frequency of service.		
04473	Anesthesia Procedure Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N203	Missing/incomplete/invalid anesthesia time/units	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04476	Invalid Number Of Services For Modifier Billed On Claim	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M53	Missing/incomplete/invalid days or units of service.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04476	Invalid Number Of Services For Modifier Billed On Claim	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M53	Missing/incomplete/invalid days or units of service.	476	Missing or invalid units of service		
04477	Osteotomy Procedure Allowed One Occurrence Per Day	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		
04477	Osteotomy Procedure Allowed One Occurrence Per Day	119	Benefit maximum for this time period or occurrence has been reached.					612	Per Day Limit Amount		
04478	Osteotomy And Exploration Of Spine Not Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04478	Osteotomy And Exploration Of Spine Not Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04478	Osteotomy And Exploration Of Spine Not Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04478	Osteotomy And Exploration Of Spine Not Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04479	Exploration And Osteotomy Of Spine Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04479	Exploration And Osteotomy Of Spine Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04479	Exploration And Osteotomy Of Spine Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04479	Exploration And Osteotomy Of Spine Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04480	Add-On Procedure Must Be Billed With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N122	Add-on code cannot be billed by itself.	465	Principal Procedure Code for Service(s) Rendered		
04480	Add-On Procedure Must Be Billed With Primary Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	465	Principal Procedure Code for Service(s) Rendered		
04481	Tenotomy Not Allowed Same Day As Debridement	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04481	Tenotomy Not Allowed Same Day As Debridement	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04481	Tenotomy Not Allowed Same Day As Debridement	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04481	Tenotomy Not Allowed Same Day As Debridement	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04482	Debridement Not Allowed Same Day As Tenotomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04482	Debridement Not Allowed Same Day As Tenotomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04482	Debridement Not Allowed Same Day As Tenotomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04482	Debridement Not Allowed Same Day As Tenotomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04483	Related Hip Procedure Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04483	Related Hip Procedure Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04483	Related Hip Procedure Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04483	Related Hip Procedure Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04485	Related Repair Codes Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04485	Related Repair Codes Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04485	Related Repair Codes Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04485	Related Repair Codes Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04487	Related Fracture Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04487	Related Fracture Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04487	Related Fracture Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04487	Related Fracture Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04489	Biceps Tenodesis Not Allowed Same Day As Related Arthroscop Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04489	Biceps Tenodesis Not Allowed Same Day As Related Arthroscop Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04489	Biceps Tenodesis Not Allowed Same Day As Related Arthroscop Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04489	Biceps Tenodesis Not Allowed Same Day As Related Arthroscop Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04490	Related Arthroscopy Procedures Not Allowed Same Day As Biceps Tenodesis	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04490	Related Arthroscopy Procedures Not Allowed Same Day As Biceps Tenodesis	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04490	Related Arthroscopy Procedures Not Allowed Same Day As Biceps Tenodesis	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04490	Related Arthroscopy Procedures Not Allowed Same Day As Biceps Tenodesis	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04491	Thoracentesis Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04491	Thoracentesis Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04491	Thoracentesis Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04491	Thoracentesis Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04492	Related Procedure Not Allowed Same Day As Thoracentesis. Thoracentesis Recouped					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
04492	Related Procedure Not Allowed Same Day As Thoracentesis. Thoracentesis Recouped					N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04493	Insertion Of Catheter Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04493	Insertion Of Catheter Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04493	Insertion Of Catheter Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04493	Insertion Of Catheter Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04494	Related Procedure Not Allowed Same Day As Insertion Of Catheter					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
04494	Related Procedure Not Allowed Same Day As Insertion Of Catheter					N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04495	Thoracostomy Not Allowed Same Day As Excision	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04495	Thoracostomy Not Allowed Same Day As Excision	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04495	Thoracostomy Not Allowed Same Day As Excision	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04495	Thoracostomy Not Allowed Same Day As Excision	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04496	Excision Procedure Not Allowed Same Day As Thoracostomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04496	Excision Procedure Not Allowed Same Day As Thoracostomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04496	Excision Procedure Not Allowed Same Day As Thoracostomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04496	Excision Procedure Not Allowed Same Day As Thoracostomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04497	Ablation Must Be Billed With Related Cardiac Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04497	Ablation Must Be Billed With Related Cardiac Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04497	Ablation Must Be Billed With Related Cardiac Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04497	Ablation Must Be Billed With Related Cardiac Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04498	Related Surgical Procedure Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04498	Related Surgical Procedure Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04498	Related Surgical Procedure Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04498	Related Surgical Procedure Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04499	Units Cutback. Exceeds 10 Units Per 270 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04499	Units Cutback. Exceeds 10 Units Per 270 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04501	Aorta Graft Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04501	Aorta Graft Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04501	Aorta Graft Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04501	Aorta Graft Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04502	Related Procedure Not Allowed Same Day As Aorta Graft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04502	Related Procedure Not Allowed Same Day As Aorta Graft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04502	Related Procedure Not Allowed Same Day As Aorta Graft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04502	Related Procedure Not Allowed Same Day As Aorta Graft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04503	Transcatheter Must Be Billed With Related Repair Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04503	Transcatheter Must Be Billed With Related Repair Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04503	Transcatheter Must Be Billed With Related Repair Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04503	Transcatheter Must Be Billed With Related Repair Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04504	Bypass Graft Procedure Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04504	Bypass Graft Procedure Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04504	Bypass Graft Procedure Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04504	Bypass Graft Procedure Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04505	Related Procedure Not Allowed Same Day As Bypass Graft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04505	Related Procedure Not Allowed Same Day As Bypass Graft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04505	Related Procedure Not Allowed Same Day As Bypass Graft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04505	Related Procedure Not Allowed Same Day As Bypass Graft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04506	Excision Of Tumors Not Allowed Same Day As Related Surgical Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04506	Excision Of Tumors Not Allowed Same Day As Related Surgical Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04506	Excision Of Tumors Not Allowed Same Day As Related Surgical Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04506	Excision Of Tumors Not Allowed Same Day As Related Surgical Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04507	Related Surgical Procedure Not Allowed Same Day As Excision Of Tumors	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04507	Related Surgical Procedure Not Allowed Same Day As Excision Of Tumors	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04507	Related Surgical Procedure Not Allowed Same Day As Excision Of Tumors	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04507	Related Surgical Procedure Not Allowed Same Day As Excision Of Tumors	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04510	Gastric Tube Placement Not Allowed Same Day As Related Insertion Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04510	Gastric Tube Placement Not Allowed Same Day As Related Insertion Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04510	Gastric Tube Placement Not Allowed Same Day As Related Insertion Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04510	Gastric Tube Placement Not Allowed Same Day As Related Insertion Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04511	Insertion Procedure Not Allowed Same Day As Gastric Tube Placement. Gastric Tube Placement Recouped					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
04511	Insertion Procedure Not Allowed Same Day As Gastric Tube Placement. Gastric Tube Placement Recouped					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	490	Other Procedure Code for Service(s) Rendered		
04511	Insertion Procedure Not Allowed Same Day As Gastric Tube Placement. Gastric Tube Placement Recouped					N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04511	Insertion Procedure Not Allowed Same Day As Gastric Tube Placement. Gastric Tube Placement Recouped					N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04512	Mechanical Removal Or Contrast Injection Not Allowed Same Day As Replacement Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04512	Mechanical Removal Or Contrast Injection Not Allowed Same Day As Replacement Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04512	Mechanical Removal Or Contrast Injection Not Allowed Same Day As Replacement Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04512	Mechanical Removal Or Contrast Injection Not Allowed Same Day As Replacement Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04513	Replacement Procedure Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04513	Replacement Procedure Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04513	Replacement Procedure Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04513	Replacement Procedure Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04514	Mechanical Removal Not Allowed Same Day As Insertion Contrast	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04514	Mechanical Removal Not Allowed Same Day As Insertion Contrast	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04514	Mechanical Removal Not Allowed Same Day As Insertion Contrast	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04514	Mechanical Removal Not Allowed Same Day As Insertion Contrast	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04515	Contrast Injection Not Allowed Same Day As Mechanical Removal	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04515	Contrast Injection Not Allowed Same Day As Mechanical Removal	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	490	Other Procedure Code for Service(s) Rendered		
04515	Contrast Injection Not Allowed Same Day As Mechanical Removal	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04515	Contrast Injection Not Allowed Same Day As Mechanical Removal	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	490	Other Procedure Code for Service(s) Rendered		
04517	Additional Augmentation Requires Initial Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04517	Additional Augmentation Requires Initial Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
04517	Additional Augmentation Requires Initial Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
04520	Anesthesia Assistant Services Not Allowed Same Day As Related Anesthesia Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04520	Anesthesia Assistant Services Not Allowed Same Day As Related Anesthesia Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04520	Anesthesia Assistant Services Not Allowed Same Day As Related Anesthesia Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04520	Anesthesia Assistant Services Not Allowed Same Day As Related Anesthesia Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04520	Anesthesia Assistant Services Not Allowed Same Day As Related Anesthesia Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04520	Anesthesia Assistant Services Not Allowed Same Day As Related Anesthesia Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04521	Related Anesthesia Services Not Allowed Same Day As Anesthesia Assistant Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04521	Related Anesthesia Services Not Allowed Same Day As Anesthesia Assistant Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04521	Related Anesthesia Services Not Allowed Same Day As Anesthesia Assistant Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04521	Related Anesthesia Services Not Allowed Same Day As Anesthesia Assistant Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04521	Related Anesthesia Services Not Allowed Same Day As Anesthesia Assistant Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04521	Related Anesthesia Services Not Allowed Same Day As Anesthesia Assistant Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04522	Anesthesia Stand By Not Allowed On The Same Day As An Anesthesia Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04522	Anesthesia Stand By Not Allowed On The Same Day As An Anesthesia Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04522	Anesthesia Stand By Not Allowed On The Same Day As An Anesthesia Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04522	Anesthesia Stand By Not Allowed On The Same Day As An Anesthesia Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04522	Anesthesia Stand By Not Allowed On The Same Day As An Anesthesia Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04522	Anesthesia Stand By Not Allowed On The Same Day As An Anesthesia Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04523	Anesthesia Procedure Not Allowed Same Day As Anesthesia Stand By Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04523	Anesthesia Procedure Not Allowed Same Day As Anesthesia Stand By Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04523	Anesthesia Procedure Not Allowed Same Day As Anesthesia Stand By Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04523	Anesthesia Procedure Not Allowed Same Day As Anesthesia Stand By Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04523	Anesthesia Procedure Not Allowed Same Day As Anesthesia Stand By Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04523	Anesthesia Procedure Not Allowed Same Day As Anesthesia Stand By Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04524	Only 1 Hour Of Anesthesia Stand By Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04524	Only 1 Hour Of Anesthesia Stand By Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
04524	Only 1 Hour Of Anesthesia Stand By Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04524	Only 1 Hour Of Anesthesia Stand By Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04525	Billing Locator Code Cannot Be Derived										
04526	Rendering Locator Code Cannot Be Derived										
04527	Attending Locator Code Cannot Be Derived										
04560	No Budget Or Budget Information On File										
04561	Funding For Applicable Payer Not Found										
04562	System Error From Financial System										
04563	System Error From Financial System										
04564	System Error From Financial System										
04565	System Error From Financial System										

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04612	Subcutaneous Infusion Add-On Code Must Be Billed With Primary Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
04612	Subcutaneous Infusion Add-On Code Must Be Billed With Primary Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
04613	Only One Initial Infusion Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04613	Only One Initial Infusion Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04614	Only One Additional Pump Set-Up Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04614	Only One Additional Pump Set-Up Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04615	Lab Procedure Not Allowed Same Day As Related Lab Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04615	Lab Procedure Not Allowed Same Day As Related Lab Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04615	Lab Procedure Not Allowed Same Day As Related Lab Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04615	Lab Procedure Not Allowed Same Day As Related Lab Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04615	Lab Procedure Not Allowed Same Day As Related Lab Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04615	Lab Procedure Not Allowed Same Day As Related Lab Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04616	Lab 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.		
04616	Lab 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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04616	Lab 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.		
04616	Lab 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		
04616	Lab 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.		
04616	Lab 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		
04617	Service Denied. Basic Metabolic Panel Not Allowed Same Day As Comprehensive Panel	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04617	Service Denied. Basic Metabolic Panel Not Allowed Same Day As Comprehensive Panel	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04617	Service Denied. Basic Metabolic Panel Not Allowed Same Day As Comprehensive Panel	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04617	Service Denied. Basic Metabolic Panel Not Allowed Same Day As Comprehensive Panel	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04617	Service Denied. Basic Metabolic Panel Not Allowed Same Day As Comprehensive Panel	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04617	Service Denied. Basic Metabolic Panel Not Allowed Same Day As Comprehensive Panel	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04618	Basic Metabolic Panel Recouped To Allowed 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.		
04618	Basic Metabolic Panel Recouped To Allowed Reimbursement Of Comprehensive Panel Code	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04618	Basic Metabolic Panel Recouped To Allowed 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.		
04618	Basic Metabolic Panel Recouped To Allowed Reimbursement Of Comprehensive Panel Code	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04618	Basic Metabolic Panel Recouped To Allowed 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.		
04618	Basic Metabolic Panel Recouped To Allowed Reimbursement Of Comprehensive Panel Code	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04619	Service Denied. Basic Metabolic Panel Includes Procedure As A Component Of The Panel	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M126	Missing/incomplete/invalid individual lab codes included in the test.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04619	Service Denied. Basic Metabolic Panel Includes Procedure As A Component Of The Panel	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04619	Service Denied. Basic Metabolic Panel Includes Procedure As A Component Of The Panel	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04620	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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04620	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	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		
04620	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		
04621	Service Denied. Related Procedure Not Allowed Same Day As Cardiac Mri Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04621	Service Denied. Related Procedure Not Allowed Same Day As Cardiac Mri Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04621	Service Denied. Related Procedure Not Allowed Same Day As Cardiac Mri Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04621	Service Denied. Related Procedure Not Allowed Same Day As Cardiac Mri Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04621	Service Denied. Related Procedure Not Allowed Same Day As Cardiac Mri Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04621	Service Denied. Related Procedure Not Allowed Same Day As Cardiac Mri Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04622	Service Recouped. Cardiac Mri Procedure And Related Procedure Not Allowed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04622	Service Recouped. Cardiac Mri Procedure And Related Procedure Not Allowed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04622	Service Recouped. Cardiac Mri Procedure And Related Procedure Not Allowed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04622	Service Recouped. Cardiac Mri Procedure And Related Procedure Not Allowed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04622	Service Recouped. Cardiac Mri Procedure And Related Procedure Not Allowed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04622	Service Recouped. Cardiac Mri Procedure And Related Procedure Not Allowed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04623	Service Denied. Related Cardiac Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04623	Service Denied. Related Cardiac Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04623	Service Denied. Related Cardiac Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04623	Service Denied. Related Cardiac Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04623	Service Denied. Related Cardiac Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04623	Service Denied. Related Cardiac Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04624	Service Denied. Nasolacrimal Duct Probe Procedure Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04624	Service Denied. Nasolacrimal Duct Probe Procedure Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04624	Service Denied. Nasolacrimal Duct Probe Procedure Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04624	Service Denied. Nasolacrimal Duct Probe Procedure Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04624	Service Denied. Nasolacrimal Duct Probe Procedure Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04624	Service Denied. Nasolacrimal Duct Probe Procedure Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04625	Service Denied. Related Procedure Not Allowed Same Day As Nasolacrimal Duct Probe Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04625	Service Denied. Related Procedure Not Allowed Same Day As Nasolacrimal Duct Probe Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04625	Service Denied. Related Procedure Not Allowed Same Day As Nasolacrimal Duct Probe Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04625	Service Denied. Related Procedure Not Allowed Same Day As Nasolacrimal Duct Probe Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04625	Service Denied. Related Procedure Not Allowed Same Day As Nasolacrimal Duct Probe Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04625	Service Denied. Related Procedure Not Allowed Same Day As Nasolacrimal Duct Probe Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04626	Service Denied. Laser Procedure Of Prostate Not Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04626	Service Denied. Laser Procedure Of Prostate Not Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04626	Service Denied. Laser Procedure Of Prostate Not Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04626	Service Denied. Laser Procedure Of Prostate Not Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04626	Service Denied. Laser Procedure Of Prostate Not Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04626	Service Denied. Laser Procedure Of Prostate Not Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04627	Service Denied. Related Procedure Not Allowed Same Day As Laser Procedure Of Prostate	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04627	Service Denied. Related Procedure Not Allowed Same Day As Laser Procedure Of Prostate	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04627	Service Denied. Related Procedure Not Allowed Same Day As Laser Procedure Of Prostate	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04627	Service Denied. Related Procedure Not Allowed Same Day As Laser Procedure Of Prostate	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04627	Service Denied. Related Procedure Not Allowed Same Day As Laser Procedure Of Prostate	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04627	Service Denied. Related Procedure Not Allowed Same Day As Laser Procedure Of Prostate	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04628	Service Denied. Laparoscopic Hysterectomy Not Allowed Same Day As Abdominal Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04628	Service Denied. Laparoscopic Hysterectomy Not Allowed Same Day As Abdominal Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04628	Service Denied. Laparoscopic Hysterectomy Not Allowed Same Day As Abdominal Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04628	Service Denied. Laparoscopic Hysterectomy Not Allowed Same Day As Abdominal Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04628	Service Denied. Laparoscopic Hysterectomy Not Allowed Same Day As Abdominal Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04628	Service Denied. Laparoscopic Hysterectomy Not Allowed Same Day As Abdominal Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04629	Service Denied. Abdominal Hysterectomy Not Allowed Same Day As Laparoscopic Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04629	Service Denied. Abdominal Hysterectomy Not Allowed Same Day As Laparoscopic Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04629	Service Denied. Abdominal Hysterectomy Not Allowed Same Day As Laparoscopic Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04629	Service Denied. Abdominal Hysterectomy Not Allowed Same Day As Laparoscopic Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04629	Service Denied. Abdominal Hysterectomy Not Allowed Same Day As Laparoscopic Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04629	Service Denied. Abdominal Hysterectomy Not Allowed Same Day As Laparoscopic Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04630	Service Denied. Related Surgical Procedure Not Allowed Same Day As Laparoscopic Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04630	Service Denied. Related Surgical Procedure Not Allowed Same Day As Laparoscopic Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04630	Service Denied. Related Surgical Procedure Not Allowed Same Day As Laparoscopic Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04630	Service Denied. Related Surgical Procedure Not Allowed Same Day As Laparoscopic Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04630	Service Denied. Related Surgical Procedure Not Allowed Same Day As Laparoscopic Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04630	Service Denied. Related Surgical Procedure Not Allowed Same Day As Laparoscopic Hysterectomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04631	Service Recouped. Laparoscopic Hysterectomy And Related Surgical Procedure Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04631	Service Recouped. Laparoscopic Hysterectomy And Related Surgical Procedure Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04631	Service Recouped. Laparoscopic Hysterectomy And Related Surgical Procedure Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04631	Service Recouped. Laparoscopic Hysterectomy And Related Surgical Procedure Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04631	Service Recouped. Laparoscopic Hysterectomy And Related Surgical Procedure Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04631	Service Recouped. Laparoscopic Hysterectomy And Related Surgical Procedure Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04634	Service Denied. Paravaginal Defect Repair Not Allowed Same Day As Related Surgical Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04634	Service Denied. Paravaginal Defect Repair Not Allowed Same Day As Related Surgical Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04634	Service Denied. Paravaginal Defect Repair Not Allowed Same Day As Related Surgical Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04634	Service Denied. Paravaginal Defect Repair Not Allowed Same Day As Related Surgical Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04634	Service Denied. Paravaginal Defect Repair Not Allowed Same Day As Related Surgical Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04634	Service Denied. Paravaginal Defect Repair Not Allowed Same Day As Related Surgical Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04635	Service Denied. Related Surgical Procedure Not Allowed Same Day As Paravaginal Defect Repair	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04635	Service Denied. Related Surgical Procedure Not Allowed Same Day As Paravaginal Defect Repair	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04635	Service Denied. Related Surgical Procedure Not Allowed Same Day As Paravaginal Defect Repair	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04635	Service Denied. Related Surgical Procedure Not Allowed Same Day As Paravaginal Defect Repair	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04635	Service Denied. Related Surgical Procedure Not Allowed Same Day As Paravaginal Defect Repair	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04635	Service Denied. Related Surgical Procedure Not Allowed Same Day As Paravaginal Defect Repair	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04636	Service Denied. Related Procedure Included In Laser Procedure Of Prostate Complete	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04636	Service Denied. Related Procedure Included In Laser Procedure Of Prostate Complete	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04636	Service Denied. Related Procedure Included In Laser Procedure Of Prostate Complete	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04636	Service Denied. Related Procedure Included In Laser Procedure Of Prostate Complete	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04636	Service Denied. Related Procedure Included In Laser Procedure Of Prostate Complete	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04636	Service Denied. Related Procedure Included In Laser Procedure Of Prostate Complete	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04637	Service Recouped. Laser Procedure Of Prostate Includes Related Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04637	Service Recouped. Laser Procedure Of Prostate Includes Related Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04637	Service Recouped. Laser Procedure Of Prostate Includes Related Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04637	Service Recouped. Laser Procedure Of Prostate Includes Related Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04637	Service Recouped. Laser Procedure Of Prostate Includes Related Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04637	Service Recouped. Laser Procedure Of Prostate Includes Related Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04638	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Procedures When Performed In An Office	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04638	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Procedures When Performed In An Office	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04638	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Procedures When Performed In An Office	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04638	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Procedures When Performed In An Office	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04638	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Procedures When Performed In An Office	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04638	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Procedures When Performed In An Office	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04639	Related Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services When Performed In An Office	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04639	Related Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services When Performed In An Office	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04639	Related Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services When Performed In An Office	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04639	Related Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services When Performed In An Office	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04639	Related Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services When Performed In An Office	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04639	Related Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services When Performed In An Office	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04640	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Procedures When Performed By Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04640	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Procedures When Performed By Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04640	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Procedures When Performed By Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04640	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Procedures When Performed By Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04640	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Procedures When Performed By Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04640	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Procedures When Performed By Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04641	Related Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services When Performed By Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04641	Related Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services When Performed By Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04641	Related Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services When Performed By Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04641	Related Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services When Performed By Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04641	Related Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services When Performed By Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04641	Related Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services When Performed By Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04642	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Sedation Procedures	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04642	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Sedation Procedures	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04642	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Sedation Procedures	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04642	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Sedation Procedures	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04642	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Sedation Procedures	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04642	Moderate Sedation Service Not Allowed On Same Date Of Service As Related Sedation Procedures	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04643	Related Sedation Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04643	Related Sedation Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04643	Related Sedation Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04643	Related Sedation Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04643	Related Sedation Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04643	Related Sedation Procedure Not Allowed On Same Date Of Service As Moderate Sedation Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04647	Tcm/Dd Procedure Not Allowed Same Calendar Week As Other Treatment, Service Already Rendered By Other Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04648	Other Treatment/Service Procedure Not Allowed When Tcm/Dd Is Rendered Same Calendar Week By Other Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04649	Service Denied. Procedure Code/Modifier Combination Not Allowed For Place Of Service Billed If 60 Days Have Expire From When Tcm/Dd Service Was Rendered	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04701	Missing Billing Taxonomy Code	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations			145	Entity's specialty/taxonomy code.	85	BILLING PROVIDER
04707	Related Cause Is Auto Accident And Accident Date Is Missing	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations			727	Accident date		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04708	Invalid Epsdt Indicator	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	N78	The necessary components of the child and teen checkup (EPSDT) were not completed.	564	EPSDT Indicator		
04709	Invalid Category Of Benfit Other Payer Paid Date	125	Submission/billing error(s). 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.)	CO	Contractual Obligations			516	Other Entity's Adjudication or Payment/Remittance Date.		
04710	Missing Billing Indicator	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	MA30	Missing/incomplete/invalid type of bill.	228	Type of bill for UB claim		
04772	Orthotic Or Prosthetic Equipment Allowed Once Per Two Years For Ages 003 - 115. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N129	Not eligible due to the patient's age.	258	Days/units for procedure/revenue code.		
04772	Orthotic Or Prosthetic Equipment Allowed Once Per Two Years For Ages 003 - 115. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N129	Not eligible due to the patient's age.	259	Frequency of service.		
04780	Service Denied. Differing Hyaluronan Injections Not Allowed On The Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04780	Service Denied. Differing Hyaluronan Injections Not Allowed On The Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
04780	Service Denied. Differing Hyaluronan Injections Not Allowed On The Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	612	Per Day Limit Amount		
04780	Service Denied. Differing Hyaluronan Injections Not Allowed On The Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
04780	Service Denied. Differing Hyaluronan Injections Not Allowed On The Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04780	Service Denied. Differing Hyaluronan Injections Not Allowed On The Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04780	Service Denied. Differing Hyaluronan Injections Not Allowed On The Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04780	Service Denied. Differing Hyaluronan Injections Not Allowed On The Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
04780	Service Denied. Differing Hyaluronan Injections Not Allowed On The Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04789	Papilloma Virus Vaccine Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04789	Papilloma Virus Vaccine Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04790	Papilloma Virus Vaccine Allowed Three Per Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04791	Vaccine Allowed Only Three Times Per Lifetime	149	Lifetime benefit maximum has been reached for this service/benefit category.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04798	H0040 Not Allowed Same Date Of Service With Other Enhanced Benefit Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04798	H0040 Not Allowed Same Date Of Service With Other Enhanced Benefit Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
04798	H0040 Not Allowed Same Date Of Service With Other Enhanced Benefit Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04799	Service Denied. Maximum Allowed Units Per Waiver Year For This Capmr Service Billed Have Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04800	The Maximum Allowed Monetary Limitation Per Waiver Year For The Cap/Ch Service Billed Has Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04801	The Maximum Allowed Monetary Limitation For The Cap/Ch Service Billed Has Been Exceeded For The Allowed 5 Year Period	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04802	The Maximum Allowed Unit Limitation Per Year Waiver For Cap/Ch Service Billed Has Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04803	Maximum Allowed Units Per Day For Cap/Ch Services Billed Has Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04803	Maximum Allowed Units Per Day For Cap/Ch Services Billed Has Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04804	Maximum Allowed Number Of Occurrences Per Waiver Year For Cap/Ch Service Billed Has Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04805	Only One Occurrence Allowed For Cap/Ch Service Per Recipient'S Lifetime	119	Benefit maximum for this time period or occurrence has been reached.			N117	This service is paid only once in a patient→s lifetime.	259	Frequency of service.		
04805	Only One Occurrence Allowed For Cap/Ch Service Per Recipient'S Lifetime	119	Benefit maximum for this time period or occurrence has been reached.			N117	This service is paid only once in a patient→s lifetime.	483	Maximum coverage amount met or exceeded for benefit		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04806	Cap/Ch Service Not Allowed Same Day As Hospice Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
04806	Cap/Ch Service Not Allowed Same Day As Hospice Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
04807	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.		
04807	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.		
04808	Cap/Ch Service Recouped. Cap/Ch Service Not Allowed Same Day As Hospice Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
04832	Fuzeon Can Only Be Dispensed Once Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04839	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). 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.)			M76	Missing/incomplete/invali d diagnosis or condition.	21	Missing or invalid information.		
04840	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04840	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		
04841	Orthotic Or Prosthetic Equipment Allowed Once Every 6 Months For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04841	Orthotic Or Prosthetic Equipment Allowed Once Every 6 Months For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04842	Orthotic Or Prosthetic Equipment Allowed 3 Per Foot Each Year For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04842	Orthotic Or Prosthetic Equipment Allowed 3 Per Foot Each Year For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04843	Orthotic Or Prosthetic Equipment Allow 4 Every 6 Months For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04843	Orthotic Or Prosthetic Equipment Allow 4 Every 6 Months For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04844	Orthotic Or Prosthetic Equipment Allowed Once In Three Years For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04844	Orthotic Or Prosthetic Equipment Allowed Once In Three Years For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04845	Orthotic Or Prosthetic Equipment Allowed Four Per Year For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04845	Orthotic Or Prosthetic Equipment Allowed Four Per Year For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
04846	Orthotic Or Prosthetic Equipment Allowed Six Per Year For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04847	Orthotic Or Prosthetic Equipment Allowed Twelve Per Year For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04848	Orthotic Or Prosthetic Equipment Allowed One Per Two Years For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04849	Orthotic Or Prosthetic Equipment Allowed Twice In One Year For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04850	Orthotic Or Prosthetic Equipment Allowed Once Per Year For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04851	Orthotic Or Prosthetic Equipment Allowed 2 Per Foot Each Year For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04852	Orthotic Or Prosthetic Equipment Allowed Twice Every 6 Months For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04853	Orthotic Or Prosthetic Equipment Allowed Once Every Two Years For Ages 021-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04854	Orthotic Or Prosthetic Equipment Allowed Once Every Six Months For Ages 021-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04855	Orthotic Or Prosthetic Equipment Allowed Once Per Five Years For Ages 021-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04856	Orthotic Or Prosthetic Equipment Allowed Four Per Year For Ages 021-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04857	Orthotic Or Prosthetic Equipment Allowed Once Every Three Years For Ages 021-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04858	Orthotic Or Prosthetic Equipment Allowed Two Per Year For Ages 021-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04859	Orthotic Or Prosthetic Equipment Allowed Once Per Year For Ages 021-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04860	Orthotic Or Prosthetic Equipment Allowed Two Every Six Months For Ages 021-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04861	Orthotic Or Prosthetic Equipment Allowed Two Per Foot Each Year For Ages 021-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04862	Orthotic Or Prosthetic Equipment Allowed Six Per Year For Ages 021-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04863	Orthotic Or Prosthetic Equipment Allowed Three Per Foot Each Year For Ages 021-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04864	Orthotic Or Prosthetic Equipment Allowed Twelve Per Year For Ages 021-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04865	Orthotic And Prosthetic Equipment Allowed Two Per Limb Every 6 Months For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04868	Orthotic And Prosthetic Equipment Allowed Two Per Limb Every 3 Years For Ages 021-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04869	Orthotic And Prosthetic Equipment Allowed Four Per Limb Every 6 Months For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04870	Orthotic And Prosthetic Equipment Allowed Four Per Limb Every 3 Years For Ages 021-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04871	Orthotic And Prosthetic Equipment Allowed Two Per Limb Every Year For Ages 000-020	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04872	Orthotic And Prosthetic Equipment Allowed Two Per Limb Every Year For Ages 021-115	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04877	Surgical Procedures Limited To 60 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.		
04878	Surgical Procedures Limited To 20 Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
04879	Units Cutback. Exceeds Maximum Units Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
04950	Money Follows The Person (Mfp) Service Not Allowed Same Day As Inpatient Claim	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	187	Date(s) of service.		
04950	Money Follows The Person (Mfp) Service Not Allowed Same Day As Inpatient Claim	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04950	Money Follows The Person (Mfp) Service Not Allowed Same Day As Inpatient Claim	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M2	Not paid separately when the patient is an inpatient.	187	Date(s) of service.		
04950	Money Follows The Person (Mfp) Service Not Allowed Same Day As Inpatient Claim	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M2	Not paid separately when the patient is an inpatient.	454	Procedure code for services rendered.		
04950	Money Follows The Person (Mfp) Service Not Allowed Same Day As Inpatient Claim	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04950	Money Follows The Person (Mfp) Service Not Allowed Same Day As Inpatient Claim	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
04951	Inpatient And Money Follows The Person (Mfp) Services Not Allowed On Same Day					MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	187	Date(s) of service.		
04951	Inpatient And Money Follows The Person (Mfp) Services Not Allowed On Same Day					MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	454	Procedure code for services rendered.		
04951	Inpatient And Money Follows The Person (Mfp) Services Not Allowed On Same Day					M2	Not paid separately when the patient is an inpatient.	187	Date(s) of service.		
04951	Inpatient And Money Follows The Person (Mfp) Services Not Allowed On Same Day					M2	Not paid separately when the patient is an inpatient.	454	Procedure code for services rendered.		
04951	Inpatient And Money Follows The Person (Mfp) Services Not Allowed On Same Day					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
04951	Inpatient And Money Follows The Person (Mfp) Services Not Allowed On Same Day					N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
04961	Units Cutback To The Amount Allowed Per Calendar Week	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04963	Units Cutback To The Amount Allowed Per Calendar Week Without Prior Approval	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
04965	Related Eye Treatment Procedure Codes Cannot Be Billed On The Same Claim By The Same Provider	96	Non-covered charge(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
04966	Units Exceeded The Maximum Allowable Amount Limit.Claim Pended For Review.Resubmit Claim With Corrected Units Within Allowable Limit					M80	Not covered when performed during the same session/date as a previously processed service for the patient.				
05003	Units Cutback. Only One Procedure Or Procedure/Modifier Combination Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
05003	Units Cutback. Only One Procedure Or Procedure/Modifier Combination Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
05003	Units Cutback. Only One Procedure Or Procedure/Modifier Combination Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	453	Procedure Code Modifier(s) for Service(s) Rendered		
05003	Units Cutback. Only One Procedure Or Procedure/Modifier Combination Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05007	Service Denied. Exceeds Maximum Units Allowed Per 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05008	Units Cutback To The Maximum Units Allowed Per 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.		
05009	Service Denied. Only One Procedure Or Procedure/Modifier Combination Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
05009	Service Denied. Only One Procedure Or Procedure/Modifier Combination Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
05009	Service Denied. Only One Procedure Or Procedure/Modifier Combination Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	453	Procedure Code Modifier(s) for Service(s) Rendered		
05009	Service Denied. Only One Procedure Or Procedure/Modifier Combination Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05017	Service Denied. Exceeds Maximum 4 Units Allowed Per 270 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.		
05018	Units Cutback. Units Billed Exceed Maximum Units Allowed	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05020	The Maximum Allowed Monetary Limitation Per Waiver Year For This Capmr/Dd Service Has Been Exceeded	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			M139	Denied services exceed the coverage limit for the demonstration.	483	Maximum coverage amount met or exceeded for benefit period.		
05065	Service Denied. In Home Care (Ihc) Services Not Allowed Same Day As Hospice	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05066	Service Recouped. In Home Care (Ihc) Service Not Allowed Same Day As Hospice					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05067	Service Denied. In Home Care (Ihc) Services Not Allowed Same Day As High Risk Intervention (Hri)-Ri Facility	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05068	Service Recouped. In Home Care (Ihc) Service Not Allowed Same Day As High Risk Intervention (Hri)					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05069	Service Denied. In Home Care (Ihc) Services Not Allowed Sameday As Home Health Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05070	Service Recouped. In Home Care (Ihc) Service Not Allowed Same Day As Home Health Service					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05071	Service Denied. In Home Care (Ihc) Services Not Allowed Same Day As Adult Care Home Personal Care Services (Pcs)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05072	Service Recouped. In Home Care (Ihc) Service Not Allowed Same Day As Adult Care Home Personal Care Services (Pcs)					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05078	Ihca Limited To 320 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05079	Service Denied. In Home Care (Ihc) Services Not Allowed Same Day As Cap Services	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05080	Service Recouped. In Home Care (Ihc) Service Not Allowed Same Day As Cap Services					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05100	Service Denied. Drug Limited To Maximum Allowed Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05100	Service Denied. Drug Limited To Maximum Allowed Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05103	Injection For Non-Esrd Use Not Allowed Same Date Of Service As Injection For Esrd Use	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05103	Injection For Non-Esrd Use Not Allowed Same Date Of Service As Injection For Esrd Use	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05103	Injection For Non-Esrd Use Not Allowed Same Date Of Service As Injection For Esrd Use	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05103	Injection For Non-Esrd Use Not Allowed Same Date Of Service As Injection For Esrd Use	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05104	Injection For Esrd Use Not Allowed Same Date Of Service As Injection For Non-Esrd Use	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05104	Injection For Esrd Use Not Allowed Same Date Of Service As Injection For Non-Esrd Use	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05104	Injection For Esrd Use Not Allowed Same Date Of Service As Injection For Non-Esrd Use	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05104	Injection For Esrd Use Not Allowed Same Date Of Service As Injection For Non-Esrd Use	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05105	Drug Limited To Maximum Allowed Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05105	Drug Limited To Maximum Allowed Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05108	Service Denied. Drug Limited To 1000 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05108	Service Denied. Drug Limited To 1000 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05108	Service Denied. Drug Limited To 1000 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05108	Service Denied. Drug Limited To 1000 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	585	Denied Charge or Non-covered Charge		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05109	Drug Limited To 1000 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05109	Drug Limited To 1000 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05109	Drug Limited To 1000 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05109	Drug Limited To 1000 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	585	Denied Charge or Non-covered Charge		
05110	Provider Enrollment Indicator Signifies Provider Must Be Enrolled In Appropriate Population Group	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
05115	Service Denied. Drug Limited To Maximum Allowed Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05115	Service Denied. Drug Limited To Maximum Allowed Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05115	Service Denied. Drug Limited To Maximum Allowed Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05115	Service Denied. Drug Limited To Maximum Allowed Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	585	Denied Charge or Non-covered Charge		
05116	Drug Limited To Maximum Allowed Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05116	Drug Limited To Maximum Allowed Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05116	Drug Limited To Maximum Allowed Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05116	Drug Limited To Maximum Allowed Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	585	Denied Charge or Non-covered Charge		
05122	The Prescriber Denial Clarification Field On The Input Claim Was Invalid. Valid Values Are '00' Thru '07'	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
05124	Multiple National Miscellaneous Procedure Codes Not Allowed On One Claim	125	Submission/billing error(s). 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.)			N61	Rebill services on separate claims.	454	Procedure code for services rendered.		
05201	Diagnostic Procedure Allowed Once Per Day Unless Billed With Appropriate Modifiers	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05202	Repeat Diagnostic Procedure Allowed Twice Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05202	Repeat Diagnostic Procedure Allowed Twice Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
05203	Service Represented By This Procedure Code/Modifier Combination Is Not Covered By The Nc Medicaid Program	96	Non-covered charge(s). 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.) 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.	453	Procedure Code Modifier(s) for Service(s) Rendered		
05203	Service Represented By This Procedure Code/Modifier Combination Is Not Covered By The Nc Medicaid Program	96	Non-covered charge(s). 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.) 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.	457	Non-Covered Day(s)		
05205	Procedure/Service Cannot Be Verified As Being Performed Following Review Of Medical Records/Operating Notes Provided	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	123	Additional information requested from entity.	72	OPERATING PHYSICIAN

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05205	Procedure/Service Cannot Be Verified As Being Performed Following Review Of Medical Records/Operating Notes Provided	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	297	Medical notes/report.	72	OPERATING PHYSICIAN
05211	Modifier Cc Is For Internal Use Only: To Be Applied Only By The Payer. Remove Modifier Cc And Resubmit Either As A New Day Claim Or An Adjustment	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
05216	Billing Of Procedures With Modifier 55 And Different Postoperative Periods Is Not Allowed On The Same Claim.	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N61	Rebill services on separate claims.	258	Days/units for procedure/revenue code.		
05221	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05221	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
05222	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
05222	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
05223	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
05223	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
05224	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
05224	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
05225	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05225	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
05226	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
05226	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
05227	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
05227	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
05228	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
05228	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
05229	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05229	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
05230	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
05230	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
05231	Only One Surgical Code Per Day Is Allowed As The Primary Procedure. Another Code Has Already Been Billed As Primary 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.	454	Procedure code for services rendered.		
05231	Only One Surgical Code Per Day Is Allowed As The Primary Procedure. Another Code Has Already Been Billed As Primary 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		
05232	Only One Surgical Code Per Day Is Allowed As The Primary Procedure. Another Code Has Already Been Billed As Primary For This Date Of Service. Correct Detail By Appending Modifier 51 To Claim And Rebill	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
05232	Only One Surgical Code Per Day Is Allowed As The Primary Procedure. Another Code Has Already Been Billed As Primary For This Date Of Service. Correct Detail By Appending Modifier 51 To Claim And Rebill	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
05233	Only One Surgical Code Per Day Is Allowed As The Primary Procedure. Another Code Has Already Been Billed As Primary For This Date Of Service. Correct Detail By Appending Modifier 51 To Claim And Rebill	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05234	Procedure Is Included In Open Cholecystectomy	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05238	Service Included In Ob Package	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05239	Ob Package Code Has Been Billed. Previously Billed Related Services Are Not Allowed	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05240	Service Included In Ob Package	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05241	Ob Package Code Has Been Billed. Previously Billed Related Services Are Not Allowed	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05242	Service Included In Ob Package	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05243	Ob Package Code Has Been Billed. Previously Billed Related Services Are Not Allowed	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05308	Prior Authorized Units Exceeded	198	Precertification/authorization exceeded.			N54	Claim information is inconsistent with pre-certified/authorized services.	48	Referral/authorization.		
05312	Prior Authorized Dollars Exceeded	198	Precertification/authorization exceeded.			N54	Claim information is inconsistent with pre-certified/authorized services.	48	Referral/authorization.		
05327	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05327	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05327	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05328	Units Cutback. Exceeds Maximum Units Allowed Per Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05328	Units Cutback. Exceeds Maximum Units Allowed Per Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05329	Units Cutback. Exceeds Maximum Units Allowed Per 60 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05329	Units Cutback. Exceeds Maximum Units Allowed Per 60 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05330	Units Cutback. Exceeds Maximum Units Allowed Per 225 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05330	Units Cutback. Exceeds Maximum Units Allowed Per 225 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05331	Units Cutback. Exceeds Maximum Units Allowed Per 270 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05331	Units Cutback. Exceeds Maximum Units Allowed Per 270 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05332	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05332	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05332	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05333	Units Cutback. Exceeds Maximum Units Allowed Per Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05333	Units Cutback. Exceeds Maximum Units Allowed Per Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05335	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05335	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05335	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05337	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05337	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05337	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05338	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05338	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05338	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05339	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05339	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05339	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05340	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05340	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05340	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05341	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05341	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05341	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05342	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05342	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05342	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05343	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05343	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05343	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05344	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05344	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05344	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05345	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05345	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05345	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05347	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05347	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05347	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05348	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05348	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05348	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05349	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05349	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05349	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05350	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05350	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05350	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05351	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05351	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05351	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05352	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05352	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05352	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05353	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05353	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05353	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05354	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05354	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05354	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05355	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05355	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05355	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05356	Units Cutback. Exceeds Maximum Units Allowed Per 6 Months	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		
05357	Units Cutback. Exceeds Maximum Units Allowed Per 14 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05357	Units Cutback. Exceeds Maximum Units Allowed Per 14 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05358	Units Cutback. Exceeds Maximum Units Allowed Per 30 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05358	Units Cutback. Exceeds Maximum Units Allowed Per 30 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05363	Units Cutback. Exceeds The Maximum 100 Medicaid Units Allowed Per 84 Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05363	Units Cutback. Exceeds The Maximum 100 Medicaid Units Allowed Per 84 Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05364	Units Cutback. Exceeds The Maximum 600 Units Allowed Per 9 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.		
05364	Units Cutback. Exceeds The Maximum 600 Units Allowed Per 9 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.		
05365	Procedure Code Covers Both Axillae. Units Cutback To The Allowable One Unit Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	476	Missing or invalid units of service		
05365	Procedure Code Covers Both Axillae. Units Cutback To The Allowable One Unit Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05377	Dme Incontinence Supply Limited To 192 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.		
05378	Dme Incontinence Supply Limited To 200 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.								
05400	Exact Duplicate-Same Rend Prov/Pcode/Internal Modifier/Dos/Mod/Bill Amt/Different Tcn	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	250	Type of service.		
05400	Exact Duplicate-Same Rend Prov/Pcode/Internal Modifier/Dos/Mod/Bill Amt/Different Tcn	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
05401	Duplicate-Same Rend Prov/Pcode/Internal Modifier/Dos/Related Modifier	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	250	Type of service.		
05401	Duplicate-Same Rend Prov/Pcode/Internal Modifier/Dos/Related Modifier	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
05402	Duplicate-Same Rend Prov/Pcode/Im/Dos/Related Modifiers	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	250	Type of service.		
05402	Duplicate-Same Rend Prov/Pcode/Im/Dos/Related Modifiers	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
05403	Duplicate-Same Pcode/Internal Modifier/Overlapping Dos/Related Modifiers	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	250	Type of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05403	Duplicate-Same Pcode/Internal Modifier/Overlapping Dos/Related Modifiers	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
05404	Severe Duplicate-Same Rendering Prov/Pcode/Internal Modifier/Dos/Modifier	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	250	Type of service.		
05404	Severe Duplicate-Same Rendering Prov/Pcode/Internal Modifier/Dos/Modifier	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
05405	Exact Duplicate-Same Pcode/Internal Modifier/Dos/Modifier/Bill Amount/Rend Provider/Tcn	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	250	Type of service.		
05405	Exact Duplicate-Same Pcode/Internal Modifier/Dos/Modifier/Bill Amount/Rend Provider/Tcn	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
05406	Suspect Duplicate-Same Procedure/Date Of Service/Modifier	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
05407	Severe Duplicate-Same Pcode/Overlapping Dos, Modifier Vs Modifier	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	250	Type of service.		
05407	Severe Duplicate-Same Pcode/Overlapping Dos, Modifier Vs Modifier	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05410	Severe Duplicate-Same Pcode/Internal Modifier/Modifier/Dos/Tcn	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	250	Type of service.		
05410	Severe Duplicate-Same Pcode/Internal Modifier/Modifier/Dos/Tcn	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
05500	Follow Up Care Included In Global Surgical Package	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05521	Service Recouped. Follow-Up Is Included In Global Surgery Package	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05553	Service Denied. Drug Limited To 228 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05553	Service Denied. Drug Limited To 228 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05553	Service Denied. Drug Limited To 228 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05553	Service Denied. Drug Limited To 228 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05553	Service Denied. Drug Limited To 228 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05553	Service Denied. Drug Limited To 228 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	585	Denied Charge or Non-covered Charge		
05554	Service Denied. Drug Limited To 50 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05554	Service Denied. Drug Limited To 50 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05554	Service Denied. Drug Limited To 50 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05554	Service Denied. Drug Limited To 50 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05554	Service Denied. Drug Limited To 50 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05554	Service Denied. Drug Limited To 50 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	585	Denied Charge or Non-covered Charge		
05555	Service Denied. Drug Limited To 300 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05555	Service Denied. Drug Limited To 300 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05555	Service Denied. Drug Limited To 300 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05555	Service Denied. Drug Limited To 300 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05555	Service Denied. Drug Limited To 300 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05555	Service Denied. Drug Limited To 300 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	585	Denied Charge or Non-covered Charge		
05556	Service Denied. Drug Limited To 3000 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05556	Service Denied. Drug Limited To 3000 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05556	Service Denied. Drug Limited To 3000 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05556	Service Denied. Drug Limited To 3000 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05556	Service Denied. Drug Limited To 3000 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05556	Service Denied. Drug Limited To 3000 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	585	Denied Charge or Non-covered Charge		
05557	Dme Exceeds Limitation Of $2000.00 Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
05560	Supply Of Injectable Contrast Material Requires Appropriate Procedure On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	258	Days/units for procedure/revenue code.		
05563	Drug Limited To 228 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05563	Drug Limited To 228 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05563	Drug Limited To 228 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05563	Drug Limited To 228 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05564	Drug Limited To 50 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05564	Drug Limited To 50 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05564	Drug Limited To 50 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05564	Drug Limited To 50 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05565	Drug Limited To 300 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05565	Drug Limited To 300 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05565	Drug Limited To 300 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05565	Drug Limited To 300 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05566	Drug Limited To 3000 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05566	Drug Limited To 3000 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05566	Drug Limited To 3000 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
05566	Drug Limited To 3000 Units Per Calendar Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05700	Related Endoscopy Procedure Must Be Billed With Primary Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M51	Missing/incomplete/invalid procedure code(s).	454	Procedure code for services rendered.		
05700	Related Endoscopy Procedure Must Be Billed With Primary Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M51	Missing/incomplete/invalid procedure code(s).	490	Other Procedure Code for Service(s) Rendered		
05701	Related Laparoscopy Codes Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05701	Related Laparoscopy Codes Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05701	Related Laparoscopy Codes Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
05701	Related Laparoscopy Codes Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
05701	Related Laparoscopy Codes Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05701	Related Laparoscopy Codes Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05702	Related Surgical Procedure Has Previously Paid For This Date Of Service	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	454	Procedure code for services rendered.		
05702	Related Surgical Procedure Has Previously Paid For This Date Of Service	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	666	Surgical Procedure Code		
05702	Related Surgical Procedure Has Previously Paid For This Date Of Service	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05702	Related Surgical Procedure Has Previously Paid For This Date Of Service	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			N20	Service not payable with other service rendered on the same date.	666	Surgical Procedure Code		
05703	Related Biopsy Incision Procedures Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05703	Related Biopsy Incision Procedures Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05703	Related Biopsy Incision Procedures Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05703	Related Biopsy Incision Procedures Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
05703	Related Biopsy Incision Procedures Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05703	Related Biopsy Incision Procedures Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05704	Service Recouped. Related Biopsy Incision Procedures Not On Same Day.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05704	Service Recouped. Related Biopsy Incision Procedures Not On Same Day.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05704	Service Recouped. Related Biopsy Incision Procedures Not On Same Day.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
05704	Service Recouped. Related Biopsy Incision Procedures Not On Same Day.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
05704	Service Recouped. Related Biopsy Incision Procedures Not On Same Day.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05704	Service Recouped. Related Biopsy Incision Procedures Not On Same Day.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05705	Related Surgical Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05705	Related Surgical Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05705	Related Surgical Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05705	Related Surgical Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05706	Arthroplasty Procedure Not Allowed Same Day As Microsurgery	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05706	Arthroplasty Procedure Not Allowed Same Day As Microsurgery	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05706	Arthroplasty Procedure Not Allowed Same Day As Microsurgery	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05706	Arthroplasty Procedure Not Allowed Same Day As Microsurgery	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05707	Related Autograft Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05707	Related Autograft Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05707	Related Autograft Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05707	Related Autograft Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05708	Autograft Not Allowed Same Day As Arthroscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05708	Autograft Not Allowed Same Day As Arthroscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05708	Autograft Not Allowed Same Day As Arthroscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05708	Autograft Not Allowed Same Day As Arthroscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05709	Arthroscopy Not Allowed Same Day As Autograft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05709	Arthroscopy Not Allowed Same Day As Autograft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05709	Arthroscopy Not Allowed Same Day As Autograft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05709	Arthroscopy Not Allowed Same Day As Autograft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05710	Arthroscopy Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05710	Arthroscopy Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05710	Arthroscopy Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05710	Arthroscopy Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05711	Related Procedure Not Allowed Same Day As Arthroscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05711	Related Procedure Not Allowed Same Day As Arthroscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05711	Related Procedure Not Allowed Same Day As Arthroscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05711	Related Procedure Not Allowed Same Day As Arthroscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05712	Bypass Graft Not Allowed Same Day As Related Vein Procedure.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05712	Bypass Graft Not Allowed Same Day As Related Vein Procedure.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05712	Bypass Graft Not Allowed Same Day As Related Vein Procedure.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05712	Bypass Graft Not Allowed Same Day As Related Vein Procedure.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05713	Related Vein Procedure Not Allowed Same Day As Bypass Graft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05713	Related Vein Procedure Not Allowed Same Day As Bypass Graft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05713	Related Vein Procedure Not Allowed Same Day As Bypass Graft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05713	Related Vein Procedure Not Allowed Same Day As Bypass Graft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05714	Bypass Graft Of Vein Not Allowed Same Day As Repair Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05714	Bypass Graft Of Vein Not Allowed Same Day As Repair Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05714	Bypass Graft Of Vein Not Allowed Same Day As Repair Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05714	Bypass Graft Of Vein Not Allowed Same Day As Repair Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05715	Repair Procedure Of Vein Not Allowed Same Day As Bypass Graft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05715	Repair Procedure Of Vein Not Allowed Same Day As Bypass Graft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05715	Repair Procedure Of Vein Not Allowed Same Day As Bypass Graft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05715	Repair Procedure Of Vein Not Allowed Same Day As Bypass Graft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05716	Bypass Graft Not Allowed Same Day As Related Surgical Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05716	Bypass Graft Not Allowed Same Day As Related Surgical Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05716	Bypass Graft Not Allowed Same Day As Related Surgical Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05716	Bypass Graft Not Allowed Same Day As Related Surgical Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05717	Related Surgical Procedure Not Allowed Same Day As Bypass Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05717	Related Surgical Procedure Not Allowed Same Day As Bypass Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05717	Related Surgical Procedure Not Allowed Same Day As Bypass Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05717	Related Surgical Procedure Not Allowed Same Day As Bypass Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05718	Programming Device Evaluation Not Allowed Same Day As Peri-Procedural Device Evaluation	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05718	Programming Device Evaluation Not Allowed Same Day As Peri-Procedural Device Evaluation	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05718	Programming Device Evaluation Not Allowed Same Day As Peri-Procedural Device Evaluation	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05718	Programming Device Evaluation Not Allowed Same Day As Peri-Procedural Device Evaluation	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05719	Peri-Procedural Device Evaluation Not Allowed Same Day As Programming Device Evaluation	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05719	Peri-Procedural Device Evaluation Not Allowed Same Day As Programming Device Evaluation	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05719	Peri-Procedural Device Evaluation Not Allowed Same Day As Programming Device Evaluation	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05719	Peri-Procedural Device Evaluation Not Allowed Same Day As Programming Device Evaluation	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05720	Cardiography Procedure Not Allowed Same Day As Cardiovascular Device Monitoring	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05720	Cardiography Procedure Not Allowed Same Day As Cardiovascular Device Monitoring	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05720	Cardiography Procedure Not Allowed Same Day As Cardiovascular Device Monitoring	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05720	Cardiography Procedure Not Allowed Same Day As Cardiovascular Device Monitoring	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05721	Cardiovascular Device Monitoring Not Allowed Same Day As Cardiography Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05721	Cardiovascular Device Monitoring Not Allowed Same Day As Cardiography Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05721	Cardiovascular Device Monitoring Not Allowed Same Day As Cardiography Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05721	Cardiovascular Device Monitoring Not Allowed Same Day As Cardiography Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05722	Related Cardiography Evaluation Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05722	Related Cardiography Evaluation Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05722	Related Cardiography Evaluation Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05722	Related Cardiography Evaluation Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05723	Related Implantable Devices Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05723	Related Implantable Devices Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05723	Related Implantable Devices Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05723	Related Implantable Devices Not Allowed On Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05724	Related Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05724	Related Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05724	Related Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05724	Related Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05725	Device Evaluation Limited To Once Per 90 Days	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05725	Device Evaluation Limited To Once Per 90 Days	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
05725	Device Evaluation Limited To Once Per 90 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05725	Device Evaluation Limited To Once Per 90 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05726	Device Evaluation Limited To One Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05726	Device Evaluation Limited To One Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
05726	Device Evaluation Limited To One Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05726	Device Evaluation Limited To One Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05727	Related Echocardiograph Procedure Requires Primary Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA66	Missing/incomplete/invalid principal procedure code.	465	Principal Procedure Code for Service(s) Rendered		
05727	Related Echocardiograph Procedure Requires Primary Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	465	Principal Procedure Code for Service(s) Rendered		
05728	Allograft Not Allowed Same Day As Related Arthroscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05728	Allograft Not Allowed Same Day As Related Arthroscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05728	Allograft Not Allowed Same Day As Related Arthroscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05728	Allograft Not Allowed Same Day As Related Arthroscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05729	Related Arthroscopy Not Allowed Same Day As Allograft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05729	Related Arthroscopy Not Allowed Same Day As Allograft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05729	Related Arthroscopy Not Allowed Same Day As Allograft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05729	Related Arthroscopy Not Allowed Same Day As Allograft	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05730	Technical Component Of Evaluation Already Paid Within 90 Days	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
05731	Professional Component Of Evaluation Already Paid Within 90 Days	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
05802	Prtf Age Must Be Less Than 21 At Time Of Admission	9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	N129	Not eligible due to the patient's age.	475	Procedure code not valid for patient age		
05809	Procedure Code Pricing Date Invalid For Dates Of Service							585	Denied Charge or Non-covered Charge		
05810	Units Cutback. Exceeds Maximum Units Allowed Per Calendar Year 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.		
05810	Units Cutback. Exceeds Maximum Units Allowed Per Calendar Year 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.	84	Service not authorized.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05811	Pricing For Procedure Code Modifier Combintion Record Is Missing Or Invalid							585	Denied Charge or Non-covered Charge		
05812	Pricing Factor Code Segment Missing Or Invalid							585	Denied Charge or Non-covered Charge		
05814	Secondary Factor Code X Percentage Segment Date Missing Or Invalid							585	Denied Charge or Non-covered Charge		
05815	Secondary Pricing Factor Code Y Post-Op Segment Date Missing Or Invalid							585	Denied Charge or Non-covered Charge		
05858	Evaluation & Management Already Paid For This Date Of Service By Same Rendering Provider. File Adjustment With Medical Documentation To Support Medical Necessity	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05858	Evaluation & Management Already Paid For This Date Of Service By Same Rendering Provider. File Adjustment With Medical Documentation To Support Medical Necessity	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	287	Medical necessity for service.		
05858	Evaluation & Management Already Paid For This Date Of Service By Same Rendering Provider. File Adjustment With Medical Documentation To Support Medical Necessity	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05858	Evaluation & Management Already Paid For This Date Of Service By Same Rendering Provider. File Adjustment With Medical Documentation To Support Medical Necessity	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	287	Medical necessity for service.		
05859	Recoup Evaluation And Management, Not Allowed Same Day As Normal Newborn Care Received By A Different Rendering Provider	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05859	Recoup Evaluation And Management, Not Allowed Same Day As Normal Newborn Care Received By A Different Rendering Provider	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05859	Recoup Evaluation And Management, Not Allowed Same Day As Normal Newborn Care Received By A Different Rendering Provider	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05859	Recoup Evaluation And Management, Not Allowed Same Day As Normal Newborn Care Received By A Different Rendering Provider	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
05860	Only One Neonatal Or Pediatric Initial Day Critical Care Service Allowed Within A 10 Day Period Per Hospitalization	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05860	Only One Neonatal Or Pediatric Initial Day Critical Care Service Allowed Within A 10 Day Period Per Hospitalization	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
05860	Only One Neonatal Or Pediatric Initial Day Critical Care Service Allowed Within A 10 Day Period Per Hospitalization	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05860	Only One Neonatal Or Pediatric Initial Day Critical Care Service Allowed Within A 10 Day Period Per Hospitalization	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05861	Daily Care And Normal Newborn Care Cannot Be Billed On The Same Date Of Service With The Same Attending Taxonomy Qualifier	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05861	Daily Care And Normal Newborn Care Cannot Be Billed On The Same Date Of Service With The Same Attending Taxonomy Qualifier	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
05862	Recoup Daily Care. Daily Care Cannot Be Billed On Same Date Of Service As Normal Newborn Care For The Same Attending Taxonomy Qualifier					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05862	Recoup Daily Care. Daily Care Cannot Be Billed On Same Date Of Service As Normal Newborn Care For The Same Attending Taxonomy Qualifier					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05862	Recoup Daily Care. Daily Care Cannot Be Billed On Same Date Of Service As Normal Newborn Care For The Same Attending Taxonomy Qualifier					M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
05862	Recoup Daily Care. Daily Care Cannot Be Billed On Same Date Of Service As Normal Newborn Care For The Same Attending Taxonomy Qualifier					M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
05862	Recoup Daily Care. Daily Care Cannot Be Billed On Same Date Of Service As Normal Newborn Care For The Same Attending Taxonomy Qualifier					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05862	Recoup Daily Care. Daily Care Cannot Be Billed On Same Date Of Service As Normal Newborn Care For The Same Attending Taxonomy Qualifier					N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05863	Inpatient Consult And Normal Newborn Care Same Attending Taxonomy Qualifier Cannot Be Billed Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05863	Inpatient Consult And Normal Newborn Care Same Attending Taxonomy Qualifier Cannot Be Billed Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
05864	Inpatient Consult Recouped. Inpatient Consult Cannot Be Billed On Same Day As Normal Newborn Care, Same Attending Taxonomy Qualifier					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05864	Inpatient Consult Recouped. Inpatient Consult Cannot Be Billed On Same Day As Normal Newborn Care, Same Attending Taxonomy Qualifier					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05864	Inpatient Consult Recouped. Inpatient Consult Cannot Be Billed On Same Day As Normal Newborn Care, Same Attending Taxonomy Qualifier					M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
05864	Inpatient Consult Recouped. Inpatient Consult Cannot Be Billed On Same Day As Normal Newborn Care, Same Attending Taxonomy Qualifier					M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
05864	Inpatient Consult Recouped. Inpatient Consult Cannot Be Billed On Same Day As Normal Newborn Care, Same Attending Taxonomy Qualifier					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05864	Inpatient Consult Recouped. Inpatient Consult Cannot Be Billed On Same Day As Normal Newborn Care, Same Attending Taxonomy Qualifier					N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05865	Initial Normal Newborn Care Not Allowed Same Date Of Service As Neonatal Or Pediatric Critical Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	258	Days/units for procedure/revenue code.		
05865	Initial Normal Newborn Care Not Allowed Same Date Of Service As Neonatal Or Pediatric Critical Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05866	Neonatal Or Pediatric Critical Care Services Not Allowed Same Date Of Service As Initial Normal Newborn Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	258	Days/units for procedure/revenue code.		
05866	Neonatal Or Pediatric Critical Care Services Not Allowed Same Date Of Service As Initial Normal Newborn Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
05867	Hospital Care/Discharge Management Not Allowed Same Day As Initial Normal Newborn Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	258	Days/units for procedure/revenue code.		
05867	Hospital Care/Discharge Management Not Allowed Same Day As Initial Normal Newborn Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
05868	Hospital Care/Discharge Management Recouped, Not Allowed Same Day As Initial Normal Newborn Care	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M2	Not paid separately when the patient is an inpatient.	259	Frequency of service.		
05868	Hospital Care/Discharge Management Recouped, Not Allowed Same Day As Initial Normal Newborn Care	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
05868	Hospital Care/Discharge Management Recouped, Not Allowed Same Day As Initial Normal Newborn Care	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05869	Daily Management Or Inpatient Consult And Neonatal/Pediatric Critical Care Services With Same Rendering Provider Taxonomy Qualifier, Not Allowed Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
05869	Daily Management Or Inpatient Consult And Neonatal/Pediatric Critical Care Services With Same Rendering Provider Taxonomy Qualifier, Not Allowed Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
05871	Only One Neonatal Or Pediatric Critical Care Global Code Is Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05871	Only One Neonatal Or Pediatric Critical Care Global Code Is Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
05871	Only One Neonatal Or Pediatric Critical Care Global Code Is Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05871	Only One Neonatal Or Pediatric Critical Care Global Code Is Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05872	Neonatal/Pediatric Critical Care Add On Code Must Be Billed With The Primary Critical Care Code	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA66	Missing/incomplete/invalid principal procedure code.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05872	Neonatal/Pediatric Critical Care Add On Code Must Be Billed With The Primary Critical Care Code	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA66	Missing/incomplete/invalid principal procedure code.	465	Principal Procedure Code for Service(s) Rendered		
05872	Neonatal/Pediatric Critical Care Add On Code Must Be Billed With The Primary Critical Care Code	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	21	Missing or invalid information.		
05872	Neonatal/Pediatric Critical Care Add On Code Must Be Billed With The Primary Critical Care Code	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	465	Principal Procedure Code for Service(s) Rendered		
05872	Neonatal/Pediatric Critical Care Add On Code Must Be Billed With The Primary Critical Care Code	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N122	Add-on code cannot be billed by itself.	21	Missing or invalid information.		
05872	Neonatal/Pediatric Critical Care Add On Code Must Be Billed With The Primary Critical Care Code	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N122	Add-on code cannot be billed by itself.	465	Principal Procedure Code for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05873	Neonatal/Pediatric Critical Care Add-On Code Units Exceed The Allowable Maximum Of 4 Units Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
05873	Neonatal/Pediatric Critical Care Add-On Code Units Exceed The Allowable Maximum Of 4 Units Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
05873	Neonatal/Pediatric Critical Care Add-On Code Units Exceed The Allowable Maximum Of 4 Units Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
05873	Neonatal/Pediatric Critical Care Add-On Code Units Exceed The Allowable Maximum Of 4 Units Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05874	Units Cutback. Neonatal/Pediatric Critical Care Add-On Code Exceed The Allowable 4 Units Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
05874	Units Cutback. Neonatal/Pediatric Critical Care Add-On Code Exceed The Allowable 4 Units Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
05874	Units Cutback. Neonatal/Pediatric Critical Care Add-On Code Exceed The Allowable 4 Units Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
05874	Units Cutback. Neonatal/Pediatric Critical Care Add-On Code Exceed The Allowable 4 Units Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
05875	Related Delivery And Birthing Codes Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05875	Related Delivery And Birthing Codes Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05875	Related Delivery And Birthing Codes Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05875	Related Delivery And Birthing Codes Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05876	Service Already Included In Neonatal/Pediatric Critical Care Global Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
05876	Service Already Included In Neonatal/Pediatric Critical Care Global Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
05877	Procedure Recouped. Rendered Same Day As Neonatal Critical Care. Covered In Payment Of Neonatal Critical Care Global Code.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05877	Procedure Recouped. Rendered Same Day As Neonatal Critical Care. Covered In Payment Of Neonatal Critical Care Global Code.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05877	Procedure Recouped. Rendered Same Day As Neonatal Critical Care. Covered In Payment Of Neonatal Critical Care Global Code.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05877	Procedure Recouped. Rendered Same Day As Neonatal Critical Care. Covered In Payment Of Neonatal Critical Care Global Code.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05878	Related E/M Code Billed By A Different Attending Is Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05878	Related E/M Code Billed By A Different Attending Is Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
05878	Related E/M Code Billed By A Different Attending Is Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05878	Related E/M Code Billed By A Different Attending Is Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
05882	Normal Newborn Care Not Allowed Same Date Of Service As Initial Hospital Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	258	Days/units for procedure/revenue code.		
05882	Normal Newborn Care Not Allowed Same Date Of Service As Initial Hospital Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05883	Initial Hospital Care Not Allowed Same Date Of Service As Normal Newborn Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	258	Days/units for procedure/revenue code.		
05883	Initial Hospital Care Not Allowed Same Date Of Service As Normal Newborn Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
05884	Only One Normal Newborn Care Or Pediatric Critical Care Service Allowed Per Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	258	Days/units for procedure/revenue code.		
05884	Only One Normal Newborn Care Or Pediatric Critical Care Service Allowed Per Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
05885	Normal Newborn Care Not Allowed Same Day As Neonatal Critical Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	258	Days/units for procedure/revenue code.		
05885	Normal Newborn Care Not Allowed Same Day As Neonatal Critical Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
05886	Normal Newborn Care Not Allowed Same Day As Hospital Discharge Management	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	258	Days/units for procedure/revenue code.		
05886	Normal Newborn Care Not Allowed Same Day As Hospital Discharge Management	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05887	Hospital Discharge Management Not Allowed The Same Date As Normal Newborn Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	258	Days/units for procedure/revenue code.		
05887	Hospital Discharge Management Not Allowed The Same Date As Normal Newborn Care	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
05888	Repositioning Procedure Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05888	Repositioning Procedure Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05888	Repositioning Procedure Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05888	Repositioning Procedure Not Allowed Same Day As Related Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05889	Related Procedures Not Allowed Same Day As Repositioning Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05889	Related Procedures Not Allowed Same Day As Repositioning Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05889	Related Procedures Not Allowed Same Day As Repositioning Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05889	Related Procedures Not Allowed Same Day As Repositioning Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05890	Alcohol/Substance Abuse Screening And Intervention Not Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05890	Alcohol/Substance Abuse Screening And Intervention Not Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05890	Alcohol/Substance Abuse Screening And Intervention Not Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05890	Alcohol/Substance Abuse Screening And Intervention Not Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05891	Related Behavior Intervention Counseling Codes Not Allowed On The Same Date Of Service.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05891	Related Behavior Intervention Counseling Codes Not Allowed On The Same Date Of Service.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05891	Related Behavior Intervention Counseling Codes Not Allowed On The Same Date Of Service.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05891	Related Behavior Intervention Counseling Codes Not Allowed On The Same Date Of Service.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
05892	Concurrent Infusion Add On Code Must Be Billed With Primary Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA66	Missing/incomplete/invalid principal procedure code.	21	Missing or invalid information.		
05892	Concurrent Infusion Add On Code Must Be Billed With Primary Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA66	Missing/incomplete/invalid principal procedure code.	465	Principal Procedure Code for Service(s) Rendered		
05892	Concurrent Infusion Add On Code Must Be Billed With Primary Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	21	Missing or invalid information.		
05892	Concurrent Infusion Add On Code Must Be Billed With Primary Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	465	Principal Procedure Code for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05892	Concurrent Infusion Add On Code Must Be Billed With Primary Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N122	Add-on code cannot be billed by itself.	21	Missing or invalid information.		
05892	Concurrent Infusion Add On Code Must Be Billed With Primary Procedure	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N122	Add-on code cannot be billed by itself.	465	Principal Procedure Code for Service(s) Rendered		
05893	Diagnostic Aspiration Not Allowed On Same Date Of Service As Related Diagnostic Procedures.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05893	Diagnostic Aspiration Not Allowed On Same Date Of Service As Related Diagnostic Procedures.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05893	Diagnostic Aspiration Not Allowed On Same Date Of Service As Related Diagnostic Procedures.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
05893	Diagnostic Aspiration Not Allowed On Same Date Of Service As Related Diagnostic Procedures.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
05893	Diagnostic Aspiration Not Allowed On Same Date Of Service As Related Diagnostic Procedures.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05893	Diagnostic Aspiration Not Allowed On Same Date Of Service As Related Diagnostic Procedures.	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05894	Related Diagnostic Procedure Not Allowed On Same Date Of Service As Diagnostic Aspiration Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05894	Related Diagnostic Procedure Not Allowed On Same Date Of Service As Diagnostic Aspiration Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05894	Related Diagnostic Procedure Not Allowed On Same Date Of Service As Diagnostic Aspiration Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
05894	Related Diagnostic Procedure Not Allowed On Same Date Of Service As Diagnostic Aspiration Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
05894	Related Diagnostic Procedure Not Allowed On Same Date Of Service As Diagnostic Aspiration Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05894	Related Diagnostic Procedure Not Allowed On Same Date Of Service As Diagnostic Aspiration Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05895	Related Radiosurgery Procedure Not Allowed Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05895	Related Radiosurgery Procedure Not Allowed Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05895	Related Radiosurgery Procedure Not Allowed Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
05895	Related Radiosurgery Procedure Not Allowed Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
05895	Related Radiosurgery Procedure Not Allowed Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05895	Related Radiosurgery Procedure Not Allowed Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05896	Related Stereotactic Services Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05896	Related Stereotactic Services Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05896	Related Stereotactic Services Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05896	Related Stereotactic Services Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
05896	Related Stereotactic Services Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05896	Related Stereotactic Services Not Allowed On The Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05897	Recoup Stereotactic Service, Not Allowed Same Day As Related					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05897	Recoup Stereotactic Service, Not Allowed Same Day As Related					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05897	Recoup Stereotactic Service, Not Allowed Same Day As Related					M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
05897	Recoup Stereotactic Service, Not Allowed Same Day As Related					M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
05897	Recoup Stereotactic Service, Not Allowed Same Day As Related					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05897	Recoup Stereotactic Service, Not Allowed Same Day As Related					N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05898	Related Injection Procedures Not Allowed On Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
05898	Related Injection Procedures Not Allowed On Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
05898	Related Injection Procedures Not Allowed On Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
05898	Related Injection Procedures Not Allowed On Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
05898	Related Injection Procedures Not Allowed On Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05898	Related Injection Procedures Not Allowed On Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
05899	Radiosurgery Add-On Code Must Be Billed With Primary	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05899	Radiosurgery Add-On Code Must Be Billed With Primary	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	465	Principal Procedure Code for Service(s) Rendered		
05899	Radiosurgery Add-On Code Must Be Billed With Primary	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
05899	Radiosurgery Add-On Code Must Be Billed With Primary	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N122	Add-on code cannot be billed by itself.	465	Principal Procedure Code for Service(s) Rendered		
05900	Spinal Stereotactic Radiosurgery Add-On Code Must Be Billed With Primary Procedure.	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	454	Procedure code for services rendered.		
05900	Spinal Stereotactic Radiosurgery Add-On Code Must Be Billed With Primary Procedure.	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	465	Principal Procedure Code for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05900	Spinal Stereotactic Radiosurgery Add-On Code Must Be Billed With Primary Procedure.	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
05900	Spinal Stereotactic Radiosurgery Add-On Code Must Be Billed With Primary Procedure.	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N122	Add-on code cannot be billed by itself.	465	Principal Procedure Code for Service(s) Rendered		
05901	Service Denied. Pdn Iou Medical Supplies Limited To One Unit Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05901	Service Denied. Pdn Iou Medical Supplies Limited To One Unit Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05902	Service Denied. Pdn Iou Medical Supplies Limited To Two Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05902	Service Denied. Pdn Iou Medical Supplies Limited To Two Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05903	Service Denied. Pdn Iou Medical Supplies Limited To Three Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05903	Service Denied. Pdn Iou Medical Supplies Limited To Three Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05904	Service Denied. Pdn Iou Medical Supplies Limited To Four Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05904	Service Denied. Pdn Iou Medical Supplies Limited To Four Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05905	Service Denied. Pdn Iou Medical Supplies Limited To Six Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05905	Service Denied. Pdn Iou Medical Supplies Limited To Six Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05906	Service Denied. Pdn Iou Medical Supplies Limited To 10 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05906	Service Denied. Pdn Iou Medical Supplies Limited To 10 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05907	Service Denied. Pdn Iou Medical Supplies Limited To 15 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05907	Service Denied. Pdn Iou Medical Supplies Limited To 15 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05908	Service Denied. Pdn Iou Medical Supplies Limited To 16 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05908	Service Denied. Pdn Iou Medical Supplies Limited To 16 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05909	Service Denied. Pdn Iou Medical Supplies Limited To 20 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05909	Service Denied. Pdn Iou Medical Supplies Limited To 20 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05910	Service Denied. Pdn Iou Medical Supplies Limited To 25 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05910	Service Denied. Pdn Iou Medical Supplies Limited To 25 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05911	Service Denied. Pdn Iou Medical Supplies Limited To 30 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05911	Service Denied. Pdn Iou Medical Supplies Limited To 30 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05912	Service Denied. Pdn Iou Medical Supplies Limited To 31 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05912	Service Denied. Pdn Iou Medical Supplies Limited To 31 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05913	Service Denied. Pdn Iou Medical Supplies Limited To 36 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05913	Service Denied. Pdn Iou Medical Supplies Limited To 36 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05914	Service Denied. Pdn Iou Medical Supplies Limited To 60 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05914	Service Denied. Pdn Iou Medical Supplies Limited To 60 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05915	Service Denied. Pdn Iou Medical Supplies Limited To 65 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05915	Service Denied. Pdn Iou Medical Supplies Limited To 65 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05916	Service Denied. Pdn Iou Medical Supplies Limited To 80 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05916	Service Denied. Pdn Iou Medical Supplies Limited To 80 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05917	Service Denied. Pdn Iou Medical Supplies Limited To 90 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05917	Service Denied. Pdn Iou Medical Supplies Limited To 90 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05918	Service Denied. Pdn Iou Medical Supplies Limited To 93 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05918	Service Denied. Pdn Iou Medical Supplies Limited To 93 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05919	Service Denied. Exceeds Maximum Limitation For Pdn Iou Medical Supplies	119	Benefit maximum 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05919	Service Denied. Exceeds Maximum Limitation For Pdn Iou Medical Supplies	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05920	Service Denied. Pdn Iou Medical Supplies Limited To 200 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05920	Service Denied. Pdn Iou Medical Supplies Limited To 200 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05921	Pdn Iou Medical Supplies Limited To One Unit Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05921	Pdn Iou Medical Supplies Limited To One Unit Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05922	Pdn Iou Medical Supplies Limited To Two Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05922	Pdn Iou Medical Supplies Limited To Two Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05923	Pdn Iou Medical Supplies Limited To Three Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05923	Pdn Iou Medical Supplies Limited To Three Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05924	Pdn Iou Medical Supplies Limited To Four Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05924	Pdn Iou Medical Supplies Limited To Four Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05925	Pdn Iou Medical Supplies Limited To Six Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05925	Pdn Iou Medical Supplies Limited To Six Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05926	Pdn Iou Medical Supplies Limited To 10 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05926	Pdn Iou Medical Supplies Limited To 10 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05927	Pdn Iou Medical Supplies Limited To 15 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05927	Pdn Iou Medical Supplies Limited To 15 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05928	Pdn Iou Medical Supplies Limited To 16 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05928	Pdn Iou Medical Supplies Limited To 16 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05929	Pdn Iou Medical Supplies Limited To 20 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05929	Pdn Iou Medical Supplies Limited To 20 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05930	Pdn Iou Medical Supplies Limited To 25 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05930	Pdn Iou Medical Supplies Limited To 25 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05931	Pdn Iou Medical Supplies Limited To 30 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05931	Pdn Iou Medical Supplies Limited To 30 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05932	Pdn Iou Medical Supplies Limited To 31 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05932	Pdn Iou Medical Supplies Limited To 31 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05933	Pdn Iou Medical Supplies Limited To 36 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05933	Pdn Iou Medical Supplies Limited To 36 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05934	Pdn Iou Medical Supplies Limited To 60 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05934	Pdn Iou Medical Supplies Limited To 60 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05935	Pdn Iou Medical Supplies Limited To 65 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05935	Pdn Iou Medical Supplies Limited To 65 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05936	Pdn Iou Medical Supplies Limited To 80 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05936	Pdn Iou Medical Supplies Limited To 80 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05937	Pdn Iou Medical Supplies Limited To 90 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05937	Pdn Iou Medical Supplies Limited To 90 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05938	Pdn Iou Medical Supplies Limited To 93 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05938	Pdn Iou Medical Supplies Limited To 93 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05939	Exceeds Maximum Limitation For Pdn Iou Medical Supplies. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05939	Exceeds Maximum Limitation For Pdn Iou Medical Supplies. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05940	Pdn Iou Medical Supplies Limited To 200 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05940	Pdn Iou Medical Supplies Limited To 200 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05941	Service Denied. Pdn Iou Medical Supplies Limited To One Unit Per Six Months.	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05941	Service Denied. Pdn Iou Medical Supplies Limited To One Unit Per Six Months.	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05942	Service Denied. Unlisted Home Visit Service Limited To Four Per 85 Days	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05942	Service Denied. Unlisted Home Visit Service Limited To Four Per 85 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.		
05943	Pdn Iou Medical Supplies Limited To One Unit Per Six Months. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05943	Pdn Iou Medical Supplies Limited To One Unit Per Six Months. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05944	Service Denied. Pdn Iou Medical Supplies Limited To Three Units Per Six Months	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05944	Service Denied. Pdn Iou Medical Supplies Limited To Three Units Per Six Months	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05945	Service Denied. Pdn Iou Medical Supplies Limited To 100 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05945	Service Denied. Pdn Iou Medical Supplies Limited To 100 Units Per Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	585	Denied Charge or Non-covered Charge		
05946	Pdn Iou Medical Supplies Limited To Three Units Per Six Months. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05946	Pdn Iou Medical Supplies Limited To Three Units Per Six Months. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05947	Pdn Iou Medical Supplies Limited To 100 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05947	Pdn Iou Medical Supplies Limited To 100 Units Per Month. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05948	Unlisted Home Visit Service Limited To Four Per 85 Days. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
05948	Unlisted Home Visit Service Limited To Four Per 85 Days. Units Cutback To Allowed Amount	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05953	Private Duty Nursing Services, Any Combination, May Not Exceed 96 Units Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
05955	Detail Priced According To Multiple Surgery Guidelines	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					259	Frequency of service.		
05955	Detail Priced According To Multiple Surgery Guidelines	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					453	Procedure Code Modifier(s) for Service(s) Rendered		
05957	Units Cutback. Exceeds Maximum Units Allowed Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05959	Units Cutback To The Maximum Units Allowed Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05961	Exceeds Units Allowed Per Calendar Week	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05961	Exceeds Units Allowed Per Calendar Week	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
05961	Exceeds Units Allowed Per Calendar Week	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05961	Exceeds Units Allowed Per Calendar Week	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
05962	Mental Health/Substance Abuse Service Not Allowed On Same Day As Related Service(S)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
05962	Mental Health/Substance Abuse Service Not Allowed On Same Day As Related Service(S)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05962	Mental Health/Substance Abuse Service Not Allowed On Same Day As Related Service(S)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
05962	Mental Health/Substance Abuse Service Not Allowed On Same Day As Related Service(S)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
05963	Exceeds Units Allowed Per Calendar Week Without Prior Approval	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05963	Exceeds Units Allowed Per Calendar Week Without Prior Approval	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
05963	Exceeds Units Allowed Per Calendar Week Without Prior Approval	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05963	Exceeds Units Allowed Per Calendar Week Without Prior Approval	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
05964	Exceeds Unit Limitation Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05964	Exceeds Unit Limitation Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
05964	Exceeds Unit Limitation Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05964	Exceeds Unit Limitation Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
05965	Exceeds Unit Limitation Per Calendar Week	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
05965	Exceeds Unit Limitation Per Calendar Week	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05965	Exceeds Unit Limitation Per Calendar Week	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05965	Exceeds Unit Limitation Per Calendar Week	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
05966	Exceeds The Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05967	Exceeds The Maximum Units Allowed Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05968	Units Cutback To The Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		
05969	Service Denied. Orthotic Or Prosthetic Equipment Allowed Once Every 18 Months For Ages 000 - 005	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N129	Not eligible due to the patient's age.	259	Frequency of service.		
05969	Service Denied. Orthotic Or Prosthetic Equipment Allowed Once Every 18 Months For Ages 000 - 005	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N129	Not eligible due to the patient's age.	483	Maximum coverage amount met or exceeded for benefit period.		
05970	Service Denied. Orthotic Or Prosthetic Equipment Allowed Once Per Three Years For Ages 006 - 115	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N129	Not eligible due to the patient's age.	259	Frequency of service.		
05970	Service Denied. Orthotic Or Prosthetic Equipment Allowed Once Per Three Years For Ages 006 - 115	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N129	Not eligible due to the patient's age.	483	Maximum coverage amount met or exceeded for benefit period.		
05971	Service Denied. Orthotic Or Prosthetic Equipment Allowed Six Per Year For Ages 000-002	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N129	Not eligible due to the patient's age.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
05971	Service Denied. Orthotic Or Prosthetic Equipment Allowed Six Per Year For Ages 000-002	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N129	Not eligible due to the patient's age.	483	Maximum coverage amount met or exceeded for benefit period.		
05972	Service Denied. Orthotic Or Prosthetic Equipment Allowed Once Per Two Years For Ages 003-115	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N129	Not eligible due to the patient's age.	259	Frequency of service.		
05972	Service Denied. Orthotic Or Prosthetic Equipment Allowed Once Per Two Years For Ages 003-115	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N129	Not eligible due to the patient's age.	483	Maximum coverage amount met or exceeded for benefit period.		
05976	Service Denied. Injection Allowed 2 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.	258	Days/units for procedure/revenue code.		
05977	Service Denied. Injection Allowed 6 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.	258	Days/units for procedure/revenue code.		
05978	Service Denied. Injection Allowed 96 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.	258	Days/units for procedure/revenue code.		
05986	Units Cutback To Allowed Amount. Injection Allowed 2 Units Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
05987	Units Cutback To Allowed Amount. Injection Allowed 6 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.		
05988	Units Cutback To Allowed Amount. Injection Allowed 96 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
06002	Cardiac Rehab Services Are Limited To 1 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.	258	Days/units for procedure/revenue code.		
06002	Cardiac Rehab Services Are Limited To 1 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.		
06002	Cardiac Rehab Services Are Limited To 1 Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
06002	Cardiac Rehab Services Are Limited To 1 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.		
06003	Service Denied. Cardiac Rehab Services Have Exceeded The 36 Unit Within 90 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.	258	Days/units for procedure/revenue code.		
06003	Service Denied. Cardiac Rehab Services Have Exceeded The 36 Unit Within 90 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.		
06003	Service Denied. Cardiac Rehab Services Have Exceeded The 36 Unit Within 90 Day Limit	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
06003	Service Denied. Cardiac Rehab Services Have Exceeded The 36 Unit Within 90 Day Limit	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
06004	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.		
06004	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
06005	Units Cutback. Exceeds Maximum Units Allowed Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
06005	Units Cutback. Exceeds Maximum Units Allowed Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
06006	Exceeds Calendar Month Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
06006	Exceeds Calendar Month Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
06006	Exceeds Calendar Month Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
06006	Exceeds Calendar Month Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
06009	Service Exceeds The 16 Units Per Date Of Service Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
06009	Service Exceeds The 16 Units Per Date Of Service Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
06009	Service Exceeds The 16 Units Per Date Of Service Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
06009	Service Exceeds The 16 Units Per Date Of Service Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
06010	Service Units Cutback To The Allowable 16 Unit Limitation Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
06010	Service Units Cutback To The Allowable 16 Unit Limitation Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
06010	Service Units Cutback To The Allowable 16 Unit Limitation Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
06010	Service Units Cutback To The Allowable 16 Unit Limitation Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
06012	Sterilization Under Both General Anesthesia And Epidural Anesthesia Not Allowed On The Same Day										
06015	Cochlear Device Implantation Requires Prior Approval For Second Procedure	197	Precertification/authorization/notification absent.			M62	Missing/incomplete/invalid treatment authorization code.	252	Authorization/certification number. This change effective 11/1/2011: Entity's authorization/certification number	85	BILLING PROVIDER
06015	Cochlear Device Implantation Requires Prior Approval For Second Procedure	197	Precertification/authorization/notification absent.			M62	Missing/incomplete/invalid treatment authorization code.	490	Other Procedure Code for Service(s) Rendered	85	BILLING PROVIDER
06023	Units Cutback. Exceeds The Allowable 42 Units Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
06023	Units Cutback. Exceeds The Allowable 42 Units Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
06033	Exceeds 42 Units Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
06033	Exceeds 42 Units Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
06034	Exceeds 25 Units Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
06034	Exceeds 25 Units Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
06035	Exceeds 6 Units Per 270 Days Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
06035	Exceeds 6 Units Per 270 Days Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
06057	Drug Limited To 11,300 Units Per Treatment Day, Units Cutback To Maximum Allowed	B5	Coverage/program guidelines were not met or were exceeded.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
06058	Drug Limited To 132,000 Units Per Calendar Month, Units Cutback To Maximum Allowed	B5	Coverage/program guidelines were not met or were exceeded.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
06074	Procedure Allowed Once Per Day Unless Billed With Appropriate Modifiers	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
06074	Procedure Allowed Once Per Day Unless Billed With Appropriate Modifiers	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
06075	This Repeat Procedure Modifier Combination Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
06075	This Repeat Procedure Modifier Combination Allowed Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
06083	Only 4 Quadrants Of Periodontal Scaling And Root Planing Allowed Every 2 Years	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		
06090	Procedure Billed Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
06091	Units Cutback. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
06092	Procedure Billed Exceeds Maximum Units Allowed Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
06093	Units Cutback. Exceeds Maximum Units Allowed Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		
06096	Exceeds Maximum Units Allowed Per 90 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
06097	Units Cutback. Exceeds Maximum Units Allowed Per 90 Days	119	Benefit maximum for this time period or occurrence has been reached.					483	Maximum coverage amount met or exceeded for benefit		
06098	Exceeds Maximum Units Allowed Per 180 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.	483	Maximum coverage amount met or exceeded for benefit period.		
06100	Exceeds Maximum Units Allowed Per 56 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.	483	Maximum coverage amount met or exceeded for benefit period.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
06101	Units Cutback. Exceeds Maximum Units Allowed Per 56 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.		
06104	Units Cutback. Exceeds Maximum Units Allowed Per 180 Days	119	Benefit maximum for this time period or occurrence has been reached.					483	Maximum coverage amount met or exceeded for benefit		
06107	Service Recouped. Related Procedure Not Allowed Same Calendar Week As Tcm/Dd Rendered By Another Provider					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
06134	Units Cutback. Exceeds The Allowable 25 Units Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
06134	Units Cutback. Exceeds The Allowable 25 Units Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
06135	Units Cutback. Exceeds The Allowable 6 Units Per 270 Days Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
06135	Units Cutback. Exceeds The Allowable 6 Units Per 270 Days Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
06171	Units Cutback To Allowed Amount. Vaccine Limited To One Per Day	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.		
06301	Premium Payment Amount Error. Claim Pended For Review							734	Verifying premium payment		
06337	Procedure Code Missing Or Invalid	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
06339	Revenue Code Is Invalid For This Type Bill	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
06702	Service Covered By Piedmont Cardinal Health Plan	24	Charges are covered under a capitation agreement/managed care plan.					585	Denied Charge or Non-covered Charge	1E	HEALTH MAINTENANCE ORGANIZATION (HMO)
06702	Service Covered By Piedmont Cardinal Health Plan	24	Charges are covered under a capitation agreement/managed care plan.					96	No agreement with entity.	1E	HEALTH MAINTENANCE ORGANIZATION (HMO)
06996	Encounter: Patient Not Covered Under Plan During Date(S) Of Service							585	Denied Charge or Non-covered Charge		
07000	Units Cutback. 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.		
07000	Units Cutback. 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		
07001	Exceeds One Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07001	Exceeds One Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07002	Units Cutback. Maximum Number Of Units Per 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.		
07002	Units Cutback. Maximum Number Of Units Per 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.		
07002	Units Cutback. Maximum Number Of Units Per 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		
07003	Exceeds Maximum Units Allowed Per Day(S)	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07003	Exceeds Maximum Units Allowed Per Day(S)	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07003	Exceeds Maximum Units Allowed Per Day(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.		
07003	Exceeds Maximum Units Allowed Per Day(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.	612	Per Day Limit Amount		
07004	Units Cutback. Maximum Number Of Units Per 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.		
07004	Units Cutback. Maximum Number Of Units Per 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.		
07005	Exceeds Maximum Units Allowed Per Week	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07005	Exceeds Maximum Units Allowed Per 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.		
07006	Units Cutback. Maximum Number Of Units Per 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.		
07006	Units Cutback. Maximum Number Of Units Per 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.		
07007	Exceeds Maximum Units Allowed Per 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.		
07007	Exceeds Maximum Units Allowed Per 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.		
07009	Exceeds Maximum Units Allowed Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07009	Exceeds Maximum Units Allowed Per Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
07011	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.		
07012	Units Cutback. Maximum Number Of Units Per 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.		
07012	Units Cutback. Maximum Number Of Units Per 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.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07013	Exceeds Maximum Units Allowed Per Fiscal 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.		
07013	Exceeds Maximum Units Allowed Per Fiscal Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
07015	Exceeds Maximum Units Allowed Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07015	Exceeds Maximum Units Allowed Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
07023	Taxonomy Invalid For Claim Provider Form										
07024	Exceeds Established Eye Exam Limit Of Two Times Per Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
07025	The Rendering Provider Is Not Affiliated With Your Provider Group. Contact The Rendering Provider And Ask Them To Complete A Managed Change Request Adding Your Provider Group Npi On The Affiliated Provider Page Within The Next Four Weeks To Prevent Claims Being Denied										
07026	Service Covered By Hmo Provider										
07050	Exceeds Limit Of One Routine Eye Exam And/Or Refraction Per Year For Recipients Under Age 21. Additional Routine Eye Exam Services Require Prior Approval Before Service Is Rendered	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
07057	Drug Limited To 11,300 Units Per Treatment Day	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07058	Drug Limited To 132,000 Units Per Calendar Month	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.		
07059	Dme Allowed 6 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.		
07062	Dispense Brand Name Drug. Generic Drug Is Non-Preferred	204	This service/equipment/drug is not covered under the patient→s current benefit plan			N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	216	Drug information.		
07074	Claim Denied. Case Management Units Billed Exceeds Annual Allowable Limit	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07075	Service Denied. Unit Limitation For Defibrillator Has Been Exceeded For The Allowed 91 Day Period	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
07100	Dilation Included In Related Laparoscopy Procedure Performed The Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07100	Dilation Included In Related Laparoscopy Procedure Performed The Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
07101	Service Recouped. Dilation Included In Related Laparoscopy Procedure Performed The Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07101	Service Recouped. Dilation Included In Related Laparoscopy Procedure Performed The Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
07102	Pricing Rate Record Required For Payer And Attending Provider	147	Provider contracted/negotiated rate expired or not on file.	CO	Contractual Obligations			181	Hospital s room rate.		
07103	Add-On Procedure For Cystometrogram Must Be Billed With A Paid Primary Procedure For Reimbursement	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07103	Add-On Procedure For Cystometrogram Must Be Billed With A Paid Primary Procedure For Reimbursement	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	465	Principal Procedure Code for Service(s) Rendered		
07107	Strapping Below The Knee Or Compression Already Paid For This Date Of Service. File Adjustment With Supporting Documentation For Reconsideration If Neccessary	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 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.		
07107	Strapping Below The Knee Or Compression Already Paid For This Date Of Service. File Adjustment With Supporting Documentation For Reconsideration If Neccessary	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
07151	Tissue Transfer, Specified Site Not Allowed When Tissue Transfer "Any Area" Billed Same Date Of Service. File Adjustment Supporting Different Areas	A1	Claim/Service denied. 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.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07151	Tissue Transfer, Specified Site Not Allowed When Tissue Transfer "Any Area" Billed Same Date Of Service. File Adjustment Supporting Different Areas	A1	Claim/Service denied. 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.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07151	Tissue Transfer, Specified Site Not Allowed When Tissue Transfer "Any Area" Billed Same Date Of Service. File Adjustment Supporting Different Areas	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07151	Tissue Transfer, Specified Site Not Allowed When Tissue Transfer "Any Area" Billed Same Date Of Service. File Adjustment Supporting Different Areas	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
07153	Related Cardiovascular Surgery Already Paid For This Date Of Service	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
07157	Related Angiography Service Previously Paid For This Date	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
07160	Service Recouped. Ultrasound Guidance Is Included In The Related Surgical Procedure Performed On The Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07160	Service Recouped. Ultrasound Guidance Is Included In The Related Surgical Procedure Performed On The Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07161	Service Denied. Ultrasound Guidance Is Included In The Related Surgical Procedure Performed On The Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07161	Service Denied. Ultrasound Guidance Is Included In The Related Surgical Procedure Performed On The Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
07199	Vestibular Function Test With Recording Already Paid For This Date Of Service	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
07300	Add-On Code Not Allowed, Primary Procedure Must Be Paid In History For Same Date Of Service By The Same Rendering Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07306	Ophthalmic Diagnostic Imaging Denied, Not Allowed On The Same Day As Related Ophthalmic Diagnostic Imaging Performed By The Same Or Different Provider	A1	Claim/Service denied. 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.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07308	Add On Code Not Allowed, Primary Procedure Must Be Paid In History For Same Date Of Service, By The Same Rendering Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07309	Related Endovascular Codes Not Allowed Same Date Of Service, Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07310	Only One Revascularization Procedure Allowed Per Day. Related Procedure Already Paid For This Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07311	Exceeds Maximum Units Allowed Per Day, By Same Rendering Provider	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
07312	Arthroscopy Surgery Codes Not Allowed Same Date Of Service As Arthroscopy Diagnostic Codes, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07313	Arthroscopic Diagnostic Codes Not Allowed Same Date Of Service As Arthroscopic Surgical Codes, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07325	Add On Code Not Allowed, Primary Procedure Must Be Paid In History For Same Date Of Service By The Same Rendering Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07326	Surgical Procedure Denied. Related Surgical Procedures Not Allowed On The Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07328	Procedure Denied. Related Procedures Not Allowed On The Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
07329	Procedure Recouped, Related Procedures Not Allowed On The Same Day					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
07330	Surgical Procedure Denied. Related Surgical Procedures Not Allowed On The Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
07333	Surgical Procedure Recouped. Related Surgical Procedures Not Allowed On The Same Day					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07336	Procedure Denied. Related Procedures Not Allowed On The Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
07337	Procedure Recouped. Related Procedures Not Allowed On The Same Day, By The Same Rendering Provider					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
07338	Procedure Denied. Related Procedures Not Allowed On The Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
07339	Procedure Recouped. Related Procedures Not Allowed On The Same Day					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
07341	Catheterization Procedure Not Allowed Same Date Of Service As Related Catheterization Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
07344	Injection Procedure Not Allowed Same Date Of Service As Catheterization Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	454	Procedure code for services rendered.		
07345	Left Catheterization Procedure Must Be Billed With Related Primary Catheterization Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07346	Pharmacological Agent Administration Must Be Billed With Catheterization Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07347	Physiological Exercise Study Must Be Billed With Catheterization Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07348	Injection Procedure Must Be Billed With Catheterization Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07349	Dilution Studies Must Be Billed With Catheterization Procedure	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07351	Catheterization Procedure Recouped When Related Catheterization Procedure Paid On Same Date Of Service					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
07354	Injection Procedure Recouped. Catheterization Procedure Already Paid On Same Date Of Service					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
07355	Service Denied. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07356	Service Denied. Exceeds Maximum Units Allowed Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
07357	Units Cutback To The Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
07358	Units Cutback To The Maximum Units Allowed Per Month	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07360	Combination Abdomen/Pelvis Ct Not Allowed Same Day As Standalone Abdomen/Pelvis Ct	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07361	Standalone Abdomen/Pelvis Ct Not Allowed Same Day As Combination Abdomen/Pelvis Ct	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07362	Related Heart Ct Procedures Not Allowed Same Day	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07363	Complete Ultrasound Of Extremeties Not Allowed Same Day As Limited Ultrasound Of Extremeties	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07364	Additional Immunization Administration Requires Primary Administration To Be Paid First, Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07365	Health Check Immunization Administrations Limited To 14 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.		
07366	Immunization Administrations 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.		
07367	E/M Service Denied. Another E/M Procedure Previously Paid For This Date Of Service, Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07369	Ophthalmoscopy Not Allowed Same Day As E/M Of The Eye, Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07370	Ophthalmoscopy Recouped. Procedure Not Allowed Same Day As E/M Of The Eye, Same Rendering Provider					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
07400	Add-On Code Not Allowed, Primary Procedure Code Must Be Paid In History For The Same Date Of Service, By The Same Rendering 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.			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
07400	Add-On Code Not Allowed, Primary Procedure Code Must Be Paid In History For The Same Date Of Service, By The Same Rendering 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.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07401	Manipulation Not Allowed Without Injection Paid In History, Same Billing 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.			N19	Procedure code incidental to primary procedure.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07402	Related Strapping Of Lower Extremity Not Allowed Same Day, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07403	Manual Therapy Not Allowed Same Day As Application Of Compression System, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07404	Related Application Of Compression System And Therapy Not Allowed Same Day, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07405	Thoracotomy Not Allowed Same Day As Removal Of Lung, Same Or Different Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07406	Removal Of Lung Not Allowed Same Day As Thoracotomy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07407	Thoracotomy Limited To Once 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.		
07407	Thoracotomy Limited To Once 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		
07408	Thoracoscopy Not Allowed Same Day As Lung Removal	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07409	Lung Removal Not Allowed Same Day As Thoracoscopy	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07410	Thoracoscopy Not Allowed Same Day As Lung Volume Reduction, Same Rendering/Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07410	Thoracoscopy Not Allowed Same Day As Lung Volume Reduction, Same Rendering/Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07411	Lung Volume Reduction Not Allowed Same Day As Thoracoscopy, Same Rendering/Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07411	Lung Volume Reduction Not Allowed Same Day As Thoracoscopy, Same Rendering/Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07412	Resection Of Thymus Not Allowed Same Day As Thymectomy, Same Rendering/Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07412	Resection Of Thymus Not Allowed Same Day As Thymectomy, Same Rendering/Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07413	Open Thymectomy Not Allowed Same Day As Resection Of Thymus, Same Rendering/Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07413	Open Thymectomy Not Allowed Same Day As Resection Of Thymus, Same Rendering/Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07414	Related Lymphadenectomy Not Allowed Same Day, Same Rendering/Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07414	Related Lymphadenectomy Not Allowed Same Day, Same Rendering/Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07415	Service Recouped. Related Lymphadenectomies Not Allowed Same Day, Same Rendering/Billing Provider					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07415	Service Recouped. Related Lymphadenectomies Not Allowed Same Day, Same Rendering/Billing Provider					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07416	Insertion And Removal Of Pacemaker Not Allowed Same Day, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07416	Insertion And Removal Of Pacemaker Not Allowed Same Day, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07417	Removal Of Pacemaker Not Allowed Same Day As Upgrade Of Pacemaker, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07417	Removal Of Pacemaker Not Allowed Same Day As Upgrade Of Pacemaker, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07418	Upgrade Of Pacemaker Not Allowed Same Day As Removal Of Pacemaker, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07418	Upgrade Of Pacemaker Not Allowed Same Day As Removal Of Pacemaker, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07419	Insertion Of Pulse Generator Not Allowed Same Day As Removal Of Pulse Generator, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07419	Insertion Of Pulse Generator Not Allowed Same Day As Removal Of Pulse Generator, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07420	Removal Of Pulse Generator Not Allowed Same Day As Insertion Of Pulse Generator, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07420	Removal Of Pulse Generator Not Allowed Same Day As Insertion Of Pulse Generator, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07421	Catheter Placement Of Kidneys Limited To Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07421	Catheter Placement Of Kidneys Limited To Once Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07422	Repositioning Of Filter Not Allowed Same Day As Insertion Of Intravascular Vena Cava Filter, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07422	Repositioning Of Filter Not Allowed Same Day As Insertion Of Intravascular Vena Cava Filter, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07423	Service Recouped. Repositioning Of Filter Not Allowed Same Day As Insertion Of Intravascular Vena Cava Filter, Same Billing Provider					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
07423	Service Recouped. Repositioning Of Filter Not Allowed Same Day As Insertion Of Intravascular Vena Cava Filter, Same Billing Provider					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07424	Removal Of Intravascular Vena Cava Filter Not Allowed Same Day As Removal Of Transcatheter Filter	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07424	Removal Of Intravascular Vena Cava Filter Not Allowed Same Day As Removal Of Transcatheter Filter	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07425	Removal Of Transcatheter Filter Not Allowed Same Day As Removal Of Intravascular Vena Cava Filter	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07425	Removal Of Transcatheter Filter Not Allowed Same Day As Removal Of Intravascular Vena Cava Filter	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07451	Application Of Skin Substitute Not Allowed Same Date Of Service As Related Procedure, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07452	Removal Of Devitalized Tissue Not Same Day As Application Of Skin Substitute, Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07455	Add-On Code Not Allowed, Primary Procedure Code Must Be Paid In History For The Same Date Of Service, By The Same Billing/Rendering Providers	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N122	Add-on code cannot be billed by itself.	454	Procedure code for services rendered.		
07455	Add-On Code Not Allowed, Primary Procedure Code Must Be Paid In History For The Same Date Of Service, By The Same Billing/Rendering Providers	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07456	Removal Of Devitalized Tissue Recouped, Not Allowed Same Day As Skin Substitute, Same Billing Provider					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07457	Application Of Skin Substitute Not Allowed Same Date Of Service As Related Procedure, Same Rendering Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07458	Application Of Skin Substitute Procedure Recouped, Only One Of This Series Allowed Per Day, Same Rendering Provider	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07476	Surgical Procedure Not Allowed On Same Date Of Service As Related Radiological Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07476	Surgical Procedure Not Allowed On Same Date Of Service As Related Radiological Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07477	Radiology Procedure Not Allowed On Same Date Of Service As Related Surgical Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07477	Radiology Procedure Not Allowed On Same Date Of Service As Related Surgical Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07478	Related Abdominal Paracentesis Procedures Not Allowed On Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07478	Related Abdominal Paracentesis Procedures Not Allowed On Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07479	Implantation Procedure Not Allowed On Same Date Of Service As Related Medical Maintenance Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07479	Implantation Procedure Not Allowed On Same Date Of Service As Related Medical Maintenance Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07480	Medical Maintenance Procedure Not Allowed On Same Date Of Service As Related Implantation Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07480	Medical Maintenance Procedure Not Allowed On Same Date Of Service As Related Implantation Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07481	Related Implantation Procedures Not Allowed On Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07481	Related Implantation Procedures Not Allowed On Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07482	Related Tomography And Fluoroscopic Procedures Not Allowed On Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07482	Related Tomography And Fluoroscopic Procedures Not Allowed On Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07483	Related Hepatobiliary Procedures Not Allowed On Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07483	Related Hepatobiliary Procedures Not Allowed On Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07484	Only One Pulmonary Imaging Procedure Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07484	Only One Pulmonary Imaging Procedure Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07485	Pulmonary Imaging Not Allowed Same Day As Related Myocardial Imaging	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07485	Pulmonary Imaging Not Allowed Same Day As Related Myocardial Imaging	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07486	Myocardial Imaging Not Allowed Same Day As Related Pulmonary Imaging	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07486	Myocardial Imaging Not Allowed Same Day As Related Pulmonary Imaging	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07487	Related Contact Lens Fitting Procedures Not Allowed Same Date Of Service By The Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07487	Related Contact Lens Fitting Procedures Not Allowed Same Date Of Service By The Same Billing Provider	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07488	Related Pulmonary Services Not Allowed Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07488	Related Pulmonary Services Not Allowed Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07490	Related Electromyography Procedures Not Allowed Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
07490	Related Electromyography Procedures Not Allowed Same Date Of Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07491	Electromyography Procedures Limited To 4 Per Date Of Service By The Same Rendering 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07491	Electromyography Procedures Limited To 4 Per Date Of Service By The Same Rendering Provider	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07492	Related Nerve Conduction Studies Limited To 1 Unit 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.		
07492	Related Nerve Conduction Studies Limited To 1 Unit 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		
07701	Combination Of Billed Modifiers Is Invalid. Please Review And Resubmit With Correct Billing Combination	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
07702	Medicaid Does Not Accept One Or More Of The Billed Modifier Please Correct The Modifier Information And Resubmit. Refer To Your Modifier Manual For Assistance If Necessary.	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07704	Provider Taxonomy Is Not Allowed To Bill The Modifier Submitted. Correct And Resubmit Denied Detail If Necessary	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
07705	Postoperative Dates Billed Are Not Within The Postop Period For The Billed Procedure. Please Correct And Resubmit	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
07706	Invalid Date Information (Month, Day, Year) Included As The Postoperative From And To Dates. Please Correct & Resubmit.	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
07707	Postoperative Dates Begin The Day Following Surgery. Please Correct Postoperative Dates And Resubmit.	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07708	Postoperative Dates Billed Are Not Within The Postop Period For The Billed Procedure. Please Correct And Resubmit.	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
07709	Cardiovascular Therapeutic Services Are Not Allowed Unless Billed With The Appropriate Modifier.	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M84	Medical code sets used must be the codes in effect at the time of service	258	Days/units for procedure/revenue code.		
07710	Procedure Must Be Rendered By An Approved Anesthesia Provider In Order To Receive Reimbursement From Medicaid	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.			N95	This provider type/provider specialty may not bill this service.	56	Awaiting eligibility determination.		
07711	One Single Vessel Service Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07711	One Single Vessel Service Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07713	Billing Of Services With Modifier Lc Is Limited To One Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07713	Billing Of Services With Modifier Lc Is Limited To One Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07714	Billing Of Services With Modifier Ld Is Limited To One Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07714	Billing Of Services With Modifier Ld Is Limited To One Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07715	Billing Of Services With Modifier Rc Is Limited To One Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07715	Billing Of Services With Modifier Rc Is Limited To One Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07716	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.		
07716	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		
07717	This Procedure Code Requires A Modifier That Signifies The Category Of Class Findings To Be Appended In Order For Medicaid To Consider Payment. Review And Resubmit New Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07717	This Procedure Code Requires A Modifier That Signifies The Category Of Class Findings To Be Appended In Order For Medicaid To Consider Payment. Review And Resubmit New Claim	125	Submission/billing error(s). 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.)			N180	This item or service does not meet the criteria for the category under which it was billed.	21	Missing or invalid information.		
07718	Coronary Intervention Service Is Not Consistent With/Or Not Covered For This Diagnosis.	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.			MA66	Missing/incomplete/invalid principal procedure code.	488	Diagnosis code(s) for the services rendered.		
07719	E&M Services Recouped. Evaluation And Management Service Is Included In The Anesthesia Global Package Billed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07720	Endoscopy Codes From Related Groups Billed With The Same Date Of Service Must Be Submitted On A Single Claim. A Code From This Group Has Previously Been Paid For This Dos	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
07721	Billing For Services Not Allowed Without Appropriate Ambulatory Surgery Center Modifier.	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07723	Overlapping Postoperative Dates Are Not Allowed During The Follow-Up Period For A Single Procedure. Please Correct Billed Postop Dates	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
07724	Diagnosis Does Not Support Billing Of Debridement Of Nails Per Medicaid Guidelines	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.		
07726	Medicaid Requires Documentation For Procedures Appended With Modifier 66 When Billing Over 3 Units Of Service.Resubmit As An Adjustment With Records Indicating All Surgeons Involved For This Dos	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA66	Missing/incomplete/invalid principal procedure code.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07726	Medicaid Requires Documentation For Procedures Appended With Modifier 66 When Billing Over 3 Units Of Service.Resubmit As An Adjustment With Records Indicating All Surgeons Involved For This Dos	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA66	Missing/incomplete/invalid principal procedure code.	294	Supporting documentation.		
07726	Medicaid Requires Documentation For Procedures Appended With Modifier 66 When Billing Over 3 Units Of Service.Resubmit As An Adjustment With Records Indicating All Surgeons Involved For This Dos	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			MA66	Missing/incomplete/invalid principal procedure code.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07726	Medicaid Requires Documentation For Procedures Appended With Modifier 66 When Billing Over 3 Units Of Service.Resubmit As An Adjustment With Records Indicating All Surgeons Involved For This Dos	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N13	Payment based on professional/technical component modifier(s).	21	Missing or invalid information.		
07726	Medicaid Requires Documentation For Procedures Appended With Modifier 66 When Billing Over 3 Units Of Service.Resubmit As An Adjustment With Records Indicating All Surgeons Involved For This Dos	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N13	Payment based on professional/technical component modifier(s).	294	Supporting documentation.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07726	Medicaid Requires Documentation For Procedures Appended With Modifier 66 When Billing Over 3 Units Of Service.Resubmit As An Adjustment With Records Indicating All Surgeons Involved For This Dos	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N13	Payment based on professional/technical component modifier(s).	453	Procedure Code Modifier(s) for Service(s) Rendered		
07726	Medicaid Requires Documentation For Procedures Appended With Modifier 66 When Billing Over 3 Units Of Service.Resubmit As An Adjustment With Records Indicating All Surgeons Involved For This Dos	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07726	Medicaid Requires Documentation For Procedures Appended With Modifier 66 When Billing Over 3 Units Of Service.Resubmit As An Adjustment With Records Indicating All Surgeons Involved For This Dos	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	294	Supporting documentation.		
07726	Medicaid Requires Documentation For Procedures Appended With Modifier 66 When Billing Over 3 Units Of Service.Resubmit As An Adjustment With Records Indicating All Surgeons Involved For This Dos	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) 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.	453	Procedure Code Modifier(s) for Service(s) Rendered		
07727	Once In A Lifetime Procedure Has Been Previously Completed. Subsequent Billings Are Not Allowed	149	Lifetime benefit maximum has been reached for this service/benefit category.			N117	This service is paid only once in a patient→s lifetime.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07728	Evaluation And Management Service Is Included In The Anesthesia Global Package	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07729	Diagnosis Billed Does Not Meet Medicaid Guidelines For Paring And Cutting Of Lesions Or Trimming Of Nondystrophic Nails	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.		
07730	Only One Discontinued Surgical Procedure Is Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07733	Evaluation And Management Included In Global Package, Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07734	Evaluation And Management Included In Global Package, Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07735	E/M Included In Global Surgical Package, Pre-Op	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07736	E/M Included In Global Surgical Package Pre-Op	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07737	E/M And Major Surgical Procedure Not Allowed For The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
07738	E/M And Major Surgical Procedure Not Allowed For The Same Date Of Service	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
07739	Decision For Surgery Has Already Been Paid For This Episode Of Care	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
07740	Service Is Included In Global Surgery Package	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07741	Service Is Included In Global Surgery Package	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07742	E/M Service Is Included In Reimbursement For Ventilation Management On The Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07743	E/M Services Recouped. E/M Service Is Included In Reimbursement For Ventilation Management On The Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07747	Unit(S) Cutback. Procedure Exceeds One Unit Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07747	Unit(S) Cutback. Procedure Exceeds One Unit Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07748	Exceeds One Procedure Per Month Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07749	Exceeds One Procedure Per 60 Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07750	Procedure Billed Exceeds One Procedure Per 225 Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07751	Exceeds One Procedure Per 270 Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07752	Exceeds Two Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07752	Exceeds Two Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07753	Monitored Anesthesia Not Supported By Diagnosis	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.		
07755	Exceeds Three Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07755	Exceeds Three Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07757	Exceeds Four Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07757	Exceeds Four Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07758	Exceeds Five Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07758	Exceeds Five Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07759	Exceeds Six Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07759	Exceeds Six Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07760	Exceeds Eight Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07760	Exceeds Eight Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07761	Exceeds Nine Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07761	Exceeds Nine Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07762	Exceeds Ten Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07762	Exceeds Ten Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07763	Exceeds 12 Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07763	Exceeds 12 Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07764	Exceeds 14 Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07764	Exceeds 14 Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07765	Exceeds 15 Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07765	Exceeds 15 Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07767	Exceeds 40 Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07767	Exceeds 40 Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07768	Exceeds Two Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07768	Exceeds Two Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07769	Exceeds 3 Procedure Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07769	Exceeds 3 Procedure Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07770	Exceeds Four Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07770	Exceeds Four Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07771	Exceeds Five Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07771	Exceeds Five Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07772	Exceeds Six Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07772	Exceeds Six Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07773	Exceeds Seven Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07773	Exceeds Seven Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07774	Exceeds 15 Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07774	Exceeds 15 Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07775	Exceeds 50 Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07775	Exceeds 50 Procedures Per Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07776	Exceeds One Procedure Per Six Months Limitation	119	Benefit maximum for this time period or occurrence has been reached.					259	Frequency of service.		
07777	Exceeds One Procedure Per 14 Days Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07778	Exceeds One Procedure Per 30 Days Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07781	Once In A Lifetime Procedure Has Been Previously Billed As Unilateral. Subsequent Complete And Same Location Services Are Not Allowed	149	Lifetime benefit maximum has been reached for this service/benefit category.			N117	This service is paid only once in a patient→s lifetime.	259	Frequency of service.		
07782	Once In A Lifetime Procedure Has Been Previously Billed As Unilateral. Subsequent Complete And Same Location Services Are Not Allowed	149	Lifetime benefit maximum has been reached for this service/benefit category.			N117	This service is paid only once in a patient→s lifetime.	259	Frequency of service.		
07783	This Surgical Procedure Previously Paid At Maximum Allowed For Primary Surgeon. If Appropriate, Rebill As Assistant Or File As An Adjustment With Documentation Of Multi-Surgeons	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	414	Necessity for concurrent care (more than one physician treating the patient)		
07783	This Surgical Procedure Previously Paid At Maximum Allowed For Primary Surgeon. If Appropriate, Rebill As Assistant Or File As An Adjustment With Documentation Of Multi-Surgeons	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
07784	This Procedure Code Has Been Billed As Primary Surgeon On A Separate Claim. If Appropriate, Rebill As Assistant Or File As An Adjustment With Documentation Of Multi-Surgeons	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	414	Necessity for concurrent care (more than one physician treating the patient)		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07784	This Procedure Code Has Been Billed As Primary Surgeon On A Separate Claim. If Appropriate, Rebill As Assistant Or File As An Adjustment With Documentation Of Multi-Surgeons	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
07785	Service Has Previously Been Paid As Assistant Surgeon	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
07786	Service Has Been Billed As A Co-Surgery Or A Team Surgery Procedure. Medicaid Does Not Allow An Assistant Surgeon When The Procedure Is Performed By Team Or Co-Surgeons	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07787	Service Has Previously Been Paid As Team Or Co-Surgery. Medicaid Does Not Allow An Assistant Surgeon When The Procedure Was Performed By A Team Or Co-Surgeons	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
07788	Claim Has Same Procedure On Multiple Details With Modifier(S) Appended, Indicating More Than One Surgeon. Medicaid Only Allows One Rendering Provider Per Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
07789	This Surgery Has Previously Been Submitted As Team Surgery	18	Exact duplicate claim/service (Use only with Group Code OA)					258	Days/units for procedure/revenue		
07790	This Surgery Has Previously Been Submitted As A Co-Surgery	18	Exact duplicate claim/service (Use only with Group Code OA)					258	Days/units for procedure/revenue		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07791	The Modifier Billed Indicates This Procedure Was Conducted As Co-Surgery Already Involving Two Surgeons	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
07792	Duplicate Billing - Same Procedure/Provider/Date Of Service, Same Or Related Modifier(S)	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
07793	Complete Procedure Has Been Previously Billed. Additional Services In The Global Period Are Not Allowed	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
07794	Part Of The Global Package For This Service Has Previously Been Billed. Additional Complete Service Is Not Allowed	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
07796	Exceeds One Per Lifetime Limitation	149	Lifetime benefit maximum has been reached for this service/benefit category.			N117	This service is paid only once in a patient→s lifetime.	259	Frequency of service.		
07797	Exceeds Two Per Lifetime Limitation	149	Lifetime benefit maximum has been reached for this service/benefit category.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07798	E/M Included In Global Surgical Package Pre-Op	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07800	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07800	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07801	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07801	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07802	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07802	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07803	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07803	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07804	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07804	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07805	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07805	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07806	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07806	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07807	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07807	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07808	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day. Refer To Ma 1999 Bulletin For Listing Of Base And Related Codes	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07808	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day. Refer To Ma 1999 Bulletin For Listing Of Base And Related Codes	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07809	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07809	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07810	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07810	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07811	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07811	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07812	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07812	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07813	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07813	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07814	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07814	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07815	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07815	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07816	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07816	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07817	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07817	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07818	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07818	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07819	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07819	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07820	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07820	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07821	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07821	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07822	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07822	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07823	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07823	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07824	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07824	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07825	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
07825	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07829	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07829	Reimbursement For Base Endoscopy Is Included In Rate For Related Endoscopy Procedure Performed Same Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
07830	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07830	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07831	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07831	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07832	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07832	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07833	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07833	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07834	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07834	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07835	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07835	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07836	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07836	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07837	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07837	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07838	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07838	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07839	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07839	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07840	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07840	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07841	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07841	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07842	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07842	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07843	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07843	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07844	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07844	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07845	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07845	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07846	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07846	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07847	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07847	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07848	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07848	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07849	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07849	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07850	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07850	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07851	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07851	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07852	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07852	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07853	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07853	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07854	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07854	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07855	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07855	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07859	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07859	Base Endoscopy Procedure Is Not Allowed When Related Endoscopy Procedure Is Performed On The Same Day	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07860	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07860	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07861	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07861	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07862	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07862	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07863	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07863	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07864	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07864	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07865	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07865	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07866	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07866	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07867	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07867	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07868	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07868	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07869	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07869	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07870	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07870	Multiple Endoscopy Procedures Performed On The Same Day Are Reimbursed According To Endoscopy Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07871	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07871	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07872	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07872	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07873	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07873	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07874	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07874	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07875	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07875	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07876	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07876	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07877	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07877	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07878	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07878	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07879	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07879	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07880	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07880	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07881	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07881	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07882	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07882	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07883	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07883	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07884	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07884	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07885	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07885	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07889	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07889	Multiple Scopy Procedures Performed On The Same Day Are Reimbursed According To Pricing Calculations Set Forth By Medicaid Guidelines	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	258	Days/units for procedure/revenue code.		
07890	Base Procedure Billed Is Discontinued. Related Procedures Are Not Allowed On The Same Date Of Service As The Base That Has Been Discontinued	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07890	Base Procedure Billed Is Discontinued. Related Procedures Are Not Allowed On The Same Date Of Service As The Base That Has Been Discontinued	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	258	Days/units for procedure/revenue code.		
07891	Related Procedures Are Not Allowed On The Same Date Of Service As The Base Procedure That Has Been Discontinued	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
07891	Related Procedures Are Not Allowed On The Same Date Of Service As The Base Procedure That Has Been Discontinued	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	258	Days/units for procedure/revenue code.		
07900	Service Or Procedure Is Included In The Anesthesia Global Package	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07901	Procedure Or Service Included In Anesthesia Global Package	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
07905	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07905	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07906	No Payment For Add-On (Zzz) Code Allowed If In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07906	No Payment For Add-On (Zzz) Code Allowed If In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07907	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07907	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07908	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07908	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07910	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07910	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07911	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07911	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07912	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07912	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07913	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07913	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07914	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07914	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07915	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07915	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07916	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07916	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07919	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07919	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07920	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07920	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07921	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07921	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07922	No Payment Allowed If Primary Procedure Is Not Paid For The 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.		
07922	No Payment Allowed If Primary Procedure Is Not Paid For The 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.		
07923	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07923	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07924	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07924	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07925	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07925	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07926	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07926	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07927	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07927	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07928	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07928	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07929	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07929	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07930	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07930	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07931	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07931	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07932	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07932	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07933	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07933	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07934	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07934	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07935	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07935	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07936	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07936	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07937	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07937	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07938	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07938	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07939	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07939	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07940	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07940	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07941	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07941	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07942	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07942	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07943	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07943	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07945	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07945	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07946	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07946	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07947	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07947	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07948	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07948	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07949	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07949	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07950	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07950	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07952	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07952	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07953	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07953	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07954	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07954	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07955	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07955	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07956	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07956	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07957	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07957	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07958	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07958	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07959	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07959	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07960	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07960	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07961	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07961	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07963	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07963	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07964	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07964	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07965	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07965	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07966	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07966	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07967	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07967	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07968	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07968	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07969	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07969	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07970	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07970	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07971	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07971	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07972	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07972	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07973	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07973	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07975	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07975	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07976	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07976	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07977	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07977	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07978	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07978	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07979	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07979	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07980	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07980	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07981	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07981	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07982	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07982	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07983	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07983	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07984	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07984	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07985	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07985	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07986	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07986	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07987	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07987	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07988	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07988	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07989	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07989	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07990	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07990	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07991	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07991	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07992	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07992	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07993	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07993	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07994	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
07994	No Payment For Add-On (Zzz) Code Allowed If 'Primary' Code In Series Is Not Paid For The Same Date Of Service, Same Provider	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
07996	Only One Surgical Code Per Day Is Allowed As The Primary Procedure. Another Code Has Already Been Billed As Primary For This Dos. Correct Detail By Appending -51 And Rebill	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
07996	Only One Surgical Code Per Day Is Allowed As The Primary Procedure. Another Code Has Already Been Billed As Primary For This Dos. Correct Detail By Appending -51 And Rebill	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07997	Only One Surgical Code Per Day Is Allowed As The Primary Procedure. Another Code Has Already Been Billed As Primary For This Dos. Correct Detail By Appending -51 And Rebill	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
07997	Only One Surgical Code Per Day Is Allowed As The Primary Procedure. Another Code Has Already Been Billed As Primary For This Dos. Correct Detail By Appending -51 And Rebill	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
07998	Evaluation And Management Service Not Allowed Within The Postoperative Period Of The Related Surgical Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	258	Days/units for procedure/revenue code.		
07999	Surgical Procedure'S Postoperative Period Includes Follow-Up Evaluation And Management 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.		
08009	Money Follows The Person (Mfp) Dollar Limitation Has Been Exceeded For This Service	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			M139	Denied services exceed the coverage limit for the demonstration.	483	Maximum coverage amount met or exceeded for benefit period.		
08010	Non-Telemedicine Service Not Allowed Same Day As A Related Telemedicine Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
08010	Non-Telemedicine Service Not Allowed Same Day As A Related Telemedicine Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
08010	Non-Telemedicine Service Not Allowed Same Day As A Related Telemedicine Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08010	Non-Telemedicine Service Not Allowed Same Day As A Related Telemedicine Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
08011	Telemedicine Service Not Allowed Same Day As A Related Non- Telemedicine Service					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
08011	Telemedicine Service Not Allowed Same Day As A Related Non- Telemedicine Service					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		
08011	Telemedicine Service Not Allowed Same Day As A Related Non- Telemedicine Service					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
08011	Telemedicine Service Not Allowed Same Day As A Related Non- Telemedicine Service					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
08012	Separate Evaluation And Management Procedure Not Allowed Same Day As A Telemedicine Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
08012	Separate Evaluation And Management Procedure Not Allowed Same Day As A Telemedicine Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
08012	Separate Evaluation And Management Procedure Not Allowed Same Day As A Telemedicine Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
08012	Separate Evaluation And Management Procedure Not Allowed Same Day As A Telemedicine Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08013	Telemedicine Service Not Allowed Same Day As A Separate Evaluation And Management Procedure					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
08013	Telemedicine Service Not Allowed Same Day As A Separate Evaluation And Management Procedure					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		
08013	Telemedicine Service Not Allowed Same Day As A Separate Evaluation And Management Procedure					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
08013	Telemedicine Service Not Allowed Same Day As A Separate Evaluation And Management Procedure					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
08014	Standby Service Not Allowed Same Day As A Telemedicine Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
08014	Standby Service Not Allowed Same Day As A Telemedicine Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			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		
08014	Standby Service Not Allowed Same Day As A Telemedicine Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
08014	Standby Service Not Allowed Same Day As A Telemedicine Procedure	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
08015	Telemedicine Service Not Allowed Same Day As A Standby Service					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08015	Telemedicine Service Not Allowed Same Day As A Standby Service					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		
08015	Telemedicine Service Not Allowed Same Day As A Standby Service					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
08015	Telemedicine Service Not Allowed Same Day As A Standby Service					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
08016	New Patient Eye Exam One Per 3 Year Limit Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
08016	New Patient Eye Exam One Per 3 Year Limit Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	263	Length of time for services rendered.		
08017	Diagnostic Procedure Allowed Once Per Day Unless Billed With Appropriate Modifiers	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
08017	Diagnostic Procedure Allowed Once Per Day Unless Billed With Appropriate Modifiers	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	263	Length of time for services rendered.		
08018	Repeat Diagnostic Procedure Allowed Twice Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
08018	Repeat Diagnostic Procedure Allowed Twice Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	263	Length of time for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08019	Money Follows The Person (Mfp) - Assistive Technology Dollar Limitation Per Recipient Lifetime Has Been Exceeded	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			M139	Denied services exceed the coverage limit for the demonstration.	483	Maximum coverage amount met or exceeded for benefit period.		
08020	Procedure Is Only Covered For Money Follows The Person Recipient	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M51	Missing/incomplete/invalid procedure code(s).	454	Procedure code for services rendered.		
08021	Service Denied. Moderate Sedation And Anesthesia Procedures Not Allowed Same Date Of Service					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
08021	Service Denied. Moderate Sedation And Anesthesia Procedures Not Allowed Same Date Of Service					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		
08021	Service Denied. Moderate Sedation And Anesthesia Procedures Not Allowed Same Date Of Service					M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
08021	Service Denied. Moderate Sedation And Anesthesia Procedures Not Allowed Same Date Of Service					M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
08021	Service Denied. Moderate Sedation And Anesthesia Procedures Not Allowed Same Date Of Service					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
08021	Service Denied. Moderate Sedation And Anesthesia Procedures Not Allowed Same Date Of Service					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08022	Service Denied. Moderate Sedation Services Not Allowed On The Same Date Of Service As Anesthesia Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
08022	Service Denied. Moderate Sedation Services Not Allowed On The Same Date Of Service As Anesthesia Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
08022	Service Denied. Moderate Sedation Services Not Allowed On The Same Date Of Service As Anesthesia Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
08022	Service Denied. Moderate Sedation Services Not Allowed On The Same Date Of Service As Anesthesia Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
08022	Service Denied. Moderate Sedation Services Not Allowed On The Same Date Of Service As Anesthesia Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
08022	Service Denied. Moderate Sedation Services Not Allowed On The Same Date Of Service As Anesthesia Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08022	Service Denied. Moderate Sedation Services Not Allowed On The Same Date Of Service As Anesthesia Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
08022	Service Denied. Moderate Sedation Services Not Allowed On The Same Date Of Service As Anesthesia Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
08022	Service Denied. Moderate Sedation Services Not Allowed On The Same Date Of Service As Anesthesia Related Procedures	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
08023	Anesthesia Related Procedure Not Allowed On The Same Date Of Service As Moderate Sedation Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
08023	Anesthesia Related Procedure Not Allowed On The Same Date Of Service As Moderate Sedation Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
08023	Anesthesia Related Procedure Not Allowed On The Same Date Of Service As Moderate Sedation Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08023	Anesthesia Related Procedure Not Allowed On The Same Date Of Service As Moderate Sedation Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
08023	Anesthesia Related Procedure Not Allowed On The Same Date Of Service As Moderate Sedation Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
08023	Anesthesia Related Procedure Not Allowed On The Same Date Of Service As Moderate Sedation Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
08023	Anesthesia Related Procedure Not Allowed On The Same Date Of Service As Moderate Sedation Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
08023	Anesthesia Related Procedure Not Allowed On The Same Date Of Service As Moderate Sedation Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
08023	Anesthesia Related Procedure Not Allowed On The Same Date Of Service As Moderate Sedation Services	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08024	Service Denied. Moderate Sedation Is Included In A Service Already Paid To The Provider In History. Reference Cpt Appendix G.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
08024	Service Denied. Moderate Sedation Is Included In A Service Already Paid To The Provider In History. Reference Cpt Appendix G.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	259	Frequency of service.		
08024	Service Denied. Moderate Sedation Is Included In A Service Already Paid To The Provider In History. Reference Cpt Appendix G.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		
08024	Service Denied. Moderate Sedation Is Included In A Service Already Paid To The Provider In History. Reference Cpt Appendix G.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
08024	Service Denied. Moderate Sedation Is Included In A Service Already Paid To The Provider In History. Reference Cpt Appendix G.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
08024	Service Denied. Moderate Sedation Is Included In A Service Already Paid To The Provider In History. Reference Cpt Appendix G.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08025	Moderate Sedation Recouped To Allow Payment Of Service Which Includes Sedation For Same Date Of Service. Reference Cpt Appendix G	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
08025	Moderate Sedation Recouped To Allow Payment Of Service Which Includes Sedation For Same Date Of Service. Reference Cpt Appendix G	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
08025	Moderate Sedation Recouped To Allow Payment Of Service Which Includes Sedation For Same Date Of Service. Reference Cpt Appendix G	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
08025	Moderate Sedation Recouped To Allow Payment Of Service Which Includes Sedation For Same Date Of Service. Reference Cpt Appendix G	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
08025	Moderate Sedation Recouped To Allow Payment Of Service Which Includes Sedation For Same Date Of Service. Reference Cpt Appendix G	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	259	Frequency of service.		
08025	Moderate Sedation Recouped To Allow Payment Of Service Which Includes Sedation For Same Date Of Service. Reference Cpt Appendix G	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08026	Moderate Sedation Add-On Code Must Be Billed With A Paid Primary Procedure For Reimbursement.	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
08027	Service Denied. Evaluation And Management Service And Moderate Sedation Not Allowed Same Date Of Service. Provider Has Been Paid For Moderate Sedation This Date					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
08027	Service Denied. Evaluation And Management Service And Moderate Sedation Not Allowed Same Date Of Service. Provider Has Been Paid For Moderate Sedation This Date					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		
08027	Service Denied. Evaluation And Management Service And Moderate Sedation Not Allowed Same Date Of Service. Provider Has Been Paid For Moderate Sedation This Date					M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
08027	Service Denied. Evaluation And Management Service And Moderate Sedation Not Allowed Same Date Of Service. Provider Has Been Paid For Moderate Sedation This Date					M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
08027	Service Denied. Evaluation And Management Service And Moderate Sedation Not Allowed Same Date Of Service. Provider Has Been Paid For Moderate Sedation This Date					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
08027	Service Denied. Evaluation And Management Service And Moderate Sedation Not Allowed Same Date Of Service. Provider Has Been Paid For Moderate Sedation This Date					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
08028	Service Denied. Moderate Sedation Not Allowed Same Date Of Service As Evaluation And Management Services. Moderate Sedation Already Paid To Provider For This Date					M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08028	Service Denied. Moderate Sedation Not Allowed Same Date Of Service As Evaluation And Management Services. Moderate Sedation Already Paid To Provider For This Date					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		
08028	Service Denied. Moderate Sedation Not Allowed Same Date Of Service As Evaluation And Management Services. Moderate Sedation Already Paid To Provider For This Date					N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
08028	Service Denied. Moderate Sedation Not Allowed Same Date Of Service As Evaluation And Management Services. Moderate Sedation Already Paid To Provider For This Date					N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
08029	Claim Denied. Inpatient Place Of Service Being Billed And Recipient Is Not Enrolled In Money Follows The Person (Mfp)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					249	Place of service.		
08030	Money Follows The Person(Mfp)/Programs Of All-Inclusive Care For The Elderly (Pace) Dollar Limitation Has Been Exceeded For This Service	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			M139	Denied services exceed the coverage limit for the demonstration.	483	Maximum coverage amount met or exceeded for benefit period.		
08031	Procedure Is Limited To 36 Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
08031	Procedure Is Limited To 36 Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
08031	Procedure Is Limited To 36 Per Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08031	Procedure Is Limited To 36 Per Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
08032	Unit Cutback. Procedure Limited To 36 Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
08032	Unit Cutback. Procedure Limited To 36 Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
08032	Unit Cutback. Procedure Limited To 36 Per Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
08032	Unit Cutback. Procedure Limited To 36 Per Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
08033	Dollar Limitation For Capmr Modification Procedures Billed Has Been Exceeded This Waiver Period	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)					483	Maximum coverage amount met or exceeded for benefit period.		
08036	Mfp-Transition Year Stability Resource(Tysr) "Demonstration" Service Provided Has Exceeded The Approved Maximum Dollar Limitation Per 365 Days	96	Non-covered charge(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08036	Mfp-Transition Year Stability Resource(Tysr) "Demonstration" Service Provided Has Exceeded The Approved Maximum Dollar Limitation Per 365 Days	96	Non-covered charge(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	454	Procedure code for services rendered.		
08037	Mfp-Transition Year Stability Resource(Tysr) "Demonstration" Service By Same Or Different Provider Has Been Cutback To The Approved Maximum Dollar Limitation Allowed Per 365 Days										
08051	Service Denied. Procedure Billed Exceeds The Allowed 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.		
08052	Service Denied. Procedure Billed Exceeds The Allowed Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
08054	Service Denied. Exceeds The Allowed Units Per Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
08073	Capmr Yearly Dollar Limtation Exceeded Procedure This Waiver Year	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)					483	Maximum coverage amount met or exceeded for benefit period.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08074	Billed Amount For This Capmr Procedure Exceeds The Dollar Limitation Allowed For The Waiver Year. Payment Has Been Reduced/Cutback To The Allowed Limit	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)					483	Maximum coverage amount met or exceeded for benefit period.		
08080	The Allowable 8 Units Per Day Limitation Has Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
08080	The Allowable 8 Units Per Day Limitation Has Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
08104	Health Check Immunization Administration Procedures Limited To 10 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		
08109	Dollar Amount Cutback To The Allowable Maximum For Money Follows The Person Waiver Year	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			M139	Denied services exceed the coverage limit for the demonstration.	483	Maximum coverage amount met or exceeded for benefit period.		
08110	Dollar Amount Cutback To The Allowable Maximum For Money Follows The Person Assistive Technology Per Recipients Lifetime	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			M139	Denied services exceed the coverage limit for the demonstration.	483	Maximum coverage amount met or exceeded for benefit period.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08111	Dollar Amount Cutback To The Allowable Maximum For Money Follows The Person Waiver Per Recipient'S Lifetime	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			M139	Denied services exceed the coverage limit for the demonstration.	483	Maximum coverage amount met or exceeded for benefit period.		
08112	Allowed Units For This Dme Procedure Code With Modifier Sc Have Been Exceeded For This Recipient'S Age	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
08115	Allowed Units For This Dme Procedure Code With Modifier Sc Have Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
08131	Service Not Allowed Greater Than 60 Days For Mfp/Pace Transitioning Recipient	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision .	585	Denied Charge or Non-covered Charge		
08171	Vaccine Limited To One Per Day	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.		
08173	Coordination Fees And Management Fees Are Reimbursed Through System Generated Claims Only	125	Submission/billing error(s). 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.)			N185	Alert: Do not resubmit this claim/service.	107	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)		
08173	Coordination Fees And Management Fees Are Reimbursed Through System Generated Claims Only	125	Submission/billing error(s). 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.)			N185	Alert: Do not resubmit this claim/service.	551	Coordination of Benefits Total Submitted Charge		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08174	Sick Visit Codes May Not Be Billed On The Same Claim Form With Health Check Screening Services	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N61	Rebill services on separate claims.	258	Days/units for procedure/revenue code.		
08175	All Other Dates Of Service Must Be Billed On A Separate Claim Form From Health Check Screening Dates Of Service	125	Submission/billing error(s). 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.)			N61	Rebill services on separate claims.	481	Claim/submission format is invalid.		
08301	Units Cutback To The Maximum Allowed 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.		
08301	Units Cutback To The Maximum Allowed 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		
08311	Units Cutback To The Maximum Allowed Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
08311	Units Cutback To The Maximum Allowed Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
08328	Attending Provider Not Eligible On Service Date(S)	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.			N290	Missing/incomplete/invalid rendering provider primary identifier.	91	Entity not eligible/not approved for dates of service.	82	RENDERING PROVIDER
08400	Hospice Patient. Contact Hospice Responsible For Patient'S Care. Refile Claim Only For Date(S) Of Service Not Covered By Hospice Benefit	96	Non-covered charge(s). 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.) 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)		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08400	Hospice Patient. Contact Hospice Responsible For Patient'S Care. Refile Claim Only For Date(S) Of Service Not Covered By Hospice Benefit	96	Non-covered charge(s). 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.) 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)		
08401	Hospice Patient. Contact Hospice Responsible For Patient'S Care. Refile Claim With Medicare For Date(S) Of Service Not Covered By Hospice Benefit	96	Non-covered charge(s). 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.) 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)		
08401	Hospice Patient. Contact Hospice Responsible For Patient'S Care. Refile Claim With Medicare For Date(S) Of Service Not Covered By Hospice Benefit	96	Non-covered charge(s). 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.) 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)		
08498	Units Cutback To Maximum Units Allowed Per Calendar Month For This Dme Iou Code	119	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.		
08499	Units Exceed Maximum Allowed Amount Per Calendar Month For This Dme Iou Code	119	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.		
08518	Dmh Filing Time Expired	29	The time limit for filing has expired.	CO	Contractual Obligations			718	Claim/service not submitted within the required timeframe		
08519	Rendering Provider Deceased	183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations			91	Entity not eligible/not approved for dates of service.	71	ATTENDING PHYSICIAN

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08521	Rendering Provider Suspended	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.	CO	Contractual Obligations			91	Entity not eligible/not approved for dates of service.	71	ATTENDING PHYSICIAN
08522	Rendering Provider Cancelled	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.	CO	Contractual Obligations			91	Entity not eligible/not approved for dates of service.	71	ATTENDING PHYSICIAN
08523	Rendering Provider On Review	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.	CO	Contractual Obligations			91	Entity not eligible/not approved for dates of service.	71	ATTENDING PHYSICIAN
08532	Billing Provider Ineligible	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.	CO	Contractual Obligations	N253	Missing/incomplete/invalid attending provider primary identifier.	91	Entity not eligible/not approved for dates of service.	85	BILLING PROVIDER
08533	Service Facility Location Cannot Be An Rendering Provider Identified As An Individual. Please Verify Your Facility Location And Resubmit Your Claim	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.	CO	Contractual Obligations	N253	Missing/incomplete/invalid attending provider primary identifier.	153	Entity's id number.	SJ	SERVICE PROVIDER
08534	Service Facility Location Is Not A Valid Iprs Rendering Provider, Or The Npi Submitted Could Not Be Mapped To One Sfl.	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.	CO	Contractual Obligations	N79	Service billed is not compatible with patient location information.	153	Entity's id number.	77	SERVICE LOCATION
08536	Invalid Rendering Provider	185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations			145	Entity's specialty/taxonomy code.	82	RENDERING PROVIDER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08536	Invalid Rendering Provider	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations			91	Entity not eligible/not approved for dates of service.	82	RENDERING PROVIDER
08537	Invalid Provider Taxonomy	125	Submission/billing error(s). 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.)	CO	Contractual Obligations	N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.	145	Entity's specialty/taxonomy code.	85	BILLING PROVIDER
08537	Invalid Provider Taxonomy	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations			145	Entity's specialty/taxonomy code.	71	ATTENDING PHYSICIAN
08557	Inpt-Hospital And/Or 3-Way Contract Yp820/Yp821 Claim Denied. Client Has Medicaid And Dmh Coverage	22	This care may be covered by another payer per coordination of benefits.					116	Claim submitted to incorrect payer.		
08560						N55	Procedures for billing with group/referring/performing providers were not followed.	91	Entity not eligible/not approved for dates of service.		
08561								187	Date(s) of service.		
08564	Service Exceeds The Allowable Of One Occurrence Within An Eligibility Period	198	Precertification/authorization exceeded.								
08565	Service Exceeds The Allowable Of Two Occurrences Per Pop Group Within A Fiscal Year	198	Precertification/authorization exceeded.								
08566	Service Exceeds The Allowable Of Four Units Per Day	198	Precertification/authorization exceeded.					612	Per Day Limit Amount		
08586	Single Stream Funding Claim	198	Precertification/authorization exceeded.			N70	Consolidated billing and payment applies.	247	Line information.		
08587	County Funds Claim	96	Non-covered charge(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N193	Specific federal/state/local program may cover this service through another payer.	247	Line information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08594	Targeted Case Management For Mental/Substance And Community Support Not Allowed In The Same Calendar Week	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)								
08596	Receipient Covered By Piedmont Benefit Plan Not Eligible For Dmh										
08597	Units Cutback To Whole Number										
08599	The Benefit Plan Is Not Matching Provider Or Recipient Eligibility Or The Service Covered							97	Patient eligibility not found with entity.	1P	PROVIDER
08620	30 Residential Level Iv Treatment Received, Prior Approval Is Required For Additional Service	198	Precertification/authorization exceeded.								
08621	60 Residential Level Iii Treatment Received, Prior Approval Is Required For Additional Service	198	Precertification/authorization exceeded.								
08622	60 Residential Level Ii Treatment Received, Prior Approval Is Required For Additional Service	198	Precertification/authorization exceeded.								
08628	Claim Denied. Maximum Allowed Occurrences Processed And Paid For Asdwi	198	Precertification/authorization exceeded.								
08645	Claim Denied. Maximum Allowed 26 Occurrences Processed And Paid, Prior Approval Is Required For Additional Service	198	Precertification/authorization exceeded.								
08648	Claim Denied. Maximum Allowed Occurrences Processed And Paid For Csdwi	198	Precertification/authorization exceeded.								
08649	Claim Denied. Maximum Allowed 26 Occurrences Have Processed And Paid, Prior Approval Is Required For Additional Service	198	Precertification/authorization exceeded.								
08652	Related Enhance Benefit Services Not Allowed On The Same Date Of Service As H0040, H2022, H2033, Or H2015:Ht	35	Lifetime benefit maximum has been reached.								
08653	Claim Denied. Service Billed Over The Maximum Allowed Amount	35	Lifetime benefit maximum has been reached.			N142	The original claim was denied. Resubmit a new claim, not a replacement claim.				

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08654	Only 16 Units Allowed Per Day Without Prior Approval. Prior Approval Is Needed Or Units Need To Be Correct And Resubmit Claim	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
08663	Service Denied. Unit Limitation Has Been Exceeded For The Services Payable With Diagnosis Code 7999	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.				
08664	Service Denied. Limitation Has Been Exceeded For The Fiscal Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.				
08665	Service Denied. Maximum Allowed Has Been Exceeded For The 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.				
08700	Per Legislative Mandate This Medicaid Claim Must Be Filed Electronically For Adjudication	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M117	Not covered unless submitted via electronic claim.	275	Claim.		
08700	Per Legislative Mandate This Medicaid Claim Must Be Filed Electronically For Adjudication	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M117	Not covered unless submitted via electronic claim.	481	Claim/submission format is invalid.		
08705	Follow-Up Care Is Included In Radiation Management	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 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.		
08706	Services Recouped. Radiation Management Paid In Follow- Up Care	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08827	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. 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.)			MA07	Alert: The claim information has also been forwarded to Medicaid for review.	123	Additional information requested from entity.	1P	PROVIDER
08827	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. 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.)			MA07	Alert: The claim information has also been forwarded to Medicaid for review.	21	Missing or invalid information.	1P	PROVIDER
08827	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. 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.)			MA07	Alert: The claim information has also been forwarded to Medicaid for review.	565	Estimated Claim Due Amount	1P	PROVIDER
08907	Service Denied. Only One Unit Per Calender Week Allowed For Mental Health/Substance Abuse Targeted Case Management	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
08907	Service Denied. Only One Unit Per Calender Week Allowed For Mental Health/Substance Abuse Targeted Case Management	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
08907	Service Denied. Only One Unit Per Calender Week Allowed For Mental Health/Substance Abuse Targeted Case Management	119	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.		
08907	Service Denied. Only One Unit Per Calender Week Allowed For Mental Health/Substance Abuse Targeted Case Management	119	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.		
08911	Service Denied. Exceeds Maximum Allowed For Specialized Therapy Evaluations Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
08952	Recipient Age Invalid Or Needs Prior Approval	6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO	Contractual Obligations	N129	Not eligible due to the patient's age.	475	Procedure code not valid for patient age	QC	PATIENT
08953	Procedure Code H0040 Must Be Billed With One Unit			CO	Contractual Obligations	M53	Missing/incomplete/invalid days or units of service.	476	Missing or invalid units of service		
08988	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. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N185	Alert: Do not resubmit this claim/service.	142	Entity's license/certification number.	1P	PROVIDER
08990	First Ndc Invalid. Verify And Enter The Correct Ndc And Submit As A New Claim	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	218	NDC number.		
08990	First Ndc Invalid. Verify And Enter The Correct Ndc And Submit As A New Claim	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N142	The original claim was denied. Resubmit a new claim, not a replacement claim.	218	NDC number.		
08999	Tenth Ndc Invalid. Verify And Enter The Correct Ndc And Submit As A New Claim	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	218	NDC number.		
08999	Tenth Ndc Invalid. Verify And Enter The Correct Ndc And Submit As A New Claim	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N142	The original claim was denied. Resubmit a new claim, not a replacement claim.	218	NDC number.		
09000	Dme Armrests Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
09000	Dme Armrests Limited To Two Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09007	Units Cutback. Maximum Number Of Units Has Been Exceeded Fo 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.		
09007	Units Cutback. Maximum Number Of Units Has Been Exceeded Fo 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.		
09011	Ndc Was Terminated For The Detail Date Of Service Billed	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	218	NDC number.		
09039	Only One Nurse In-Home Visit Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
09039	Only One Nurse In-Home Visit Allowed Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
09040	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. 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.)			M20	Missing/incomplete/invalid HCPCS.	123	Additional information requested from entity.	1P	PROVIDER
09040	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. 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.)			M20	Missing/incomplete/invalid HCPCS.	455	Revenue code for services rendered.	1P	PROVIDER
09040	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. 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.)			M20	Missing/incomplete/invalid HCPCS.	507	HCPCS	1P	PROVIDER
09041	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. 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.)			M49	Missing/incomplete/invalid value code(s) or amount(s).	726	NUBC Value Code Amount(s)		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09042	Disenfranchised Resident Is Not Eligible For Ach/Pcs Coverage	30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.			N39	Procedure code is not compatible with tooth number/letter.	91	Entity not eligible/not approved for dates of service.	QC	PATIENT
09053	Code Limited To Addition Of Antibiotics And Steroids Through Existing Iv Line	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N161	This drug/service/supply is covered only when the associated service is covered.	454	Procedure code for services rendered.		
09053	Code Limited To Addition Of Antibiotics And Steroids Through Existing Iv Line	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N192	Patient is a Medicaid/Qualified Medicare Beneficiary.	454	Procedure code for services rendered.		
09054	Technical Component Performed By The Facility. Rebill As Interpretation Only	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N194	Technical component not paid if provider does not own the equipment used.	454	Procedure code for services rendered.		
09054	Technical Component Performed By The Facility. Rebill As Interpretation Only	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
09054	Technical Component Performed By The Facility. Rebill As Interpretation Only	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N200	The professional component must be billed separately.	454	Procedure code for services rendered.		
09061	Edit Limit Exceeded							0	Cannot provide further status electronically.		
09062	Claim Denied. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09062	Claim Denied. Exceeds Maximum Units Allowed Per Day	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	612	Per Day Limit Amount		
09070	Intraoral Periapical Film Not Allowed Same Date Of Service As Intraoral Complete Series, Same Provider	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
09071	Intraoral Complete Series Not Allowed Same Date Of Service As Intraoral Periapical Film, Same Provider	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
09074	Enhanced Service Not Allowed Same Day As Other Enhanced Mental Health Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
09074	Enhanced Service Not Allowed Same Day As Other Enhanced Mental Health Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
09074	Enhanced Service Not Allowed Same Day As Other Enhanced Mental Health Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
09074	Enhanced Service Not Allowed Same Day As Other Enhanced Mental Health Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09075	Exceeds The Maximum 4 Units Allowed Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
09075	Exceeds The Maximum 4 Units Allowed Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
09075	Exceeds The Maximum 4 Units Allowed Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
09075	Exceeds The Maximum 4 Units Allowed Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
09076	Exceeds The Maximum Unit(S) Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
09076	Exceeds The Maximum Unit(S) 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.		
09076	Exceeds The Maximum Unit(S) Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
09076	Exceeds The Maximum Unit(S) Per Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
09077	Units Cutback To Allow The Maximum Of 4 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09077	Units Cutback To Allow The Maximum Of 4 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
09077	Units Cutback To Allow The Maximum Of 4 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
09077	Units Cutback To Allow The Maximum Of 4 Units Per Calendar Month	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
09078	Enhanced Benefit Service Not Allowed Same Day As Other Enhanced Mental Health Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
09078	Enhanced Benefit Service Not Allowed Same Day As Other Enhanced Mental Health Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
09078	Enhanced Benefit Service Not Allowed Same Day As Other Enhanced Mental Health Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
09078	Enhanced Benefit Service Not Allowed Same Day As Other Enhanced Mental Health Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
09079	Enhanced Benefit Service Not Allowed Same Date Of Service With Other Periodic Mental Health Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
09079	Enhanced Benefit Service Not Allowed Same Date Of Service With Other Periodic Mental Health Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09079	Enhanced Benefit Service Not Allowed Same Date Of Service With Other Periodic Mental Health Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
09079	Enhanced Benefit Service Not Allowed Same Date Of Service With Other Periodic Mental Health Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
09080	Enhanced Benefit Service Not Allowed Same Day As Inpatient Service Paid To A Mental Health/Psychiatric Facility	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	187	Date(s) of service.		
09080	Enhanced Benefit Service Not Allowed Same Day As Inpatient Service Paid To A Mental Health/Psychiatric Facility	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	454	Procedure code for services rendered.		
09080	Enhanced Benefit Service Not Allowed Same Day As Inpatient Service Paid To A Mental Health/Psychiatric Facility	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
09080	Enhanced Benefit Service Not Allowed Same Day As Inpatient Service Paid To A Mental Health/Psychiatric Facility	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
09080	Enhanced Benefit Service Not Allowed Same Day As Inpatient Service Paid To A Mental Health/Psychiatric Facility	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
09080	Enhanced Benefit Service Not Allowed Same Day As Inpatient Service Paid To A Mental Health/Psychiatric Facility	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09082	Enhanced Benefit Service Not Allowed Same Day As Other Enhanced Mental Health Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
09082	Enhanced Benefit Service Not Allowed Same Day As Other Enhanced Mental Health Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
09082	Enhanced Benefit Service Not Allowed Same Day As Other Enhanced Mental Health Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
09082	Enhanced Benefit Service Not Allowed Same Day As Other Enhanced Mental Health Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
09083	Enhanced Service Not Allowed Same Day As Psych Resident Treatment Facility Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	187	Date(s) of service.		
09083	Enhanced Service Not Allowed Same Day As Psych Resident Treatment Facility Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	454	Procedure code for services rendered.		
09083	Enhanced Service Not Allowed Same Day As Psych Resident Treatment Facility Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
09083	Enhanced Service Not Allowed Same Day As Psych Resident Treatment Facility Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09083	Enhanced Service Not Allowed Same Day As Psych Resident Treatment Facility Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
09083	Enhanced Service Not Allowed Same Day As Psych Resident Treatment Facility Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
09084	Enhanced Service Not Allowed Same Date Of Service As Inpatient Hospital Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	187	Date(s) of service.		
09084	Enhanced Service Not Allowed Same Date Of Service As Inpatient Hospital Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	454	Procedure code for services rendered.		
09084	Enhanced Service Not Allowed Same Date Of Service As Inpatient Hospital Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
09084	Enhanced Service Not Allowed Same Date Of Service As Inpatient Hospital Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
09084	Enhanced Service Not Allowed Same Date Of Service As Inpatient Hospital Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
09084	Enhanced Service Not Allowed Same Date Of Service As Inpatient Hospital Service	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N20	Service not payable with other service rendered on the same date.	454	Procedure code for services rendered.		
09085	Claim Submitted More Than Two Years After The Drug Obsolete Date. Claim Is Denied	B5	Coverage/program guidelines were not met or were exceeded.			N182	This claim/service must be billed according to the schedule for this plan.	216	Drug information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09085	Claim Submitted More Than Two Years After The Drug Obsolete Date. Claim Is Denied	B5	Coverage/program guidelines were not met or were exceeded.			N182	This claim/service must be billed according to the schedule for this plan.	275	Claim.		
09085	Claim Submitted More Than Two Years After The Drug Obsolete Date. Claim Is Denied	B5	Coverage/program guidelines were not met or were exceeded.			N182	This claim/service must be billed according to the schedule for this plan.	718	Claim/service not submitted within the required timeframe (timely filing).		
09086	Units Cutback To Allow The Maximum Of 480 Units Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
09086	Units Cutback To Allow The Maximum Of 480 Units Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
09086	Units Cutback To Allow The Maximum Of 480 Units Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	476	Missing or invalid units of service		
09097	The Drug Class Of The Tenth Submitted Ndc Must Match The Drug Class Of The Submitted Hcpcs Drug Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/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.		
09097	The Drug Class Of The Tenth Submitted Ndc Must Match The Drug Class Of The Submitted Hcpcs Drug Code	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09106	Consent/Statement Does Not Meet Federal Requirements	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N3	Missing consent form.	21	Missing or invalid information.		
09106	Consent/Statement Does Not Meet Federal Requirements	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N3	Missing consent form.	297	Medical notes/report.		
09108	Units Cutback To Allow The Maximum Of 1 Unit Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		
09108	Units Cutback To Allow The Maximum Of 1 Unit Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09108	Units Cutback To Allow The Maximum Of 1 Unit Per Day	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	476	Missing or invalid units of service		
09111	Submit Meters With Bin #610415. For Assistance Call 1-877-906-8969	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
09112	Diabetic Supply Limit Exceeded										
09117	Recipient Has Lock-In Record For Claim Dos	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N77	Missing/incomplete/invalid designated provider number.	97	Patient eligibility not found with entity.	QA	PHARMACY
09133	Claim Denied. Procedure Limited To One Occurrence Per 84 Day Period	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
09133	Claim Denied. Procedure Limited To One Occurrence Per 84 Day Period	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
09144	Claim Denied. Exceeds Maximum Units Allowed Per 90 Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
09144	Claim Denied. Exceeds Maximum Units Allowed Per 90 Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
09144	Claim Denied. Exceeds Maximum Units Allowed Per 90 Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	258	Days/units for procedure/revenue code.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09144	Claim Denied. Exceeds Maximum Units Allowed Per 90 Day Limitation	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
09145	Procedure Code Covers Both Axillae, Only One Unit Can Be Approved	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	476	Missing or invalid units of service		
09145	Procedure Code Covers Both Axillae, Only One Unit Can Be Approved	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	612	Per Day Limit Amount		
09145	Procedure Code Covers Both Axillae, Only One Unit Can Be Approved	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N362	The number of Days or Units of Service exceeds our acceptable maximum.	476	Missing or invalid units of service		
09145	Procedure Code Covers Both Axillae, Only One Unit Can Be Approved	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N362	The number of Days or Units of Service exceeds our acceptable maximum.	612	Per Day Limit Amount		
09147	Claim Denied. Evaluation And Management Procedure Not Allowed Same Date Of Service As Administration Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
09147	Claim Denied. Evaluation And Management Procedure Not Allowed Same Date Of Service As Administration Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09147	Claim Denied. Evaluation And Management Procedure Not Allowed Same Date Of Service As Administration Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	187	Date(s) of service.		
09147	Claim Denied. Evaluation And Management Procedure Not Allowed Same Date Of Service As Administration Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M86	Service denied because payment already made for same/similar procedure within set time frame.	453	Procedure Code Modifier(s) for Service(s) Rendered		
09147	Claim Denied. Evaluation And Management Procedure Not Allowed Same Date Of Service As Administration Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
09147	Claim Denied. Evaluation And Management Procedure Not Allowed Same Date Of Service As Administration Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
09148	Evaluation And Management Recouped. E&M Procedure And Administration Procedure Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	187	Date(s) of service.		
09148	Evaluation And Management Recouped. E&M Procedure And Administration Procedure Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	453	Procedure Code Modifier(s) for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09148	Evaluation And Management Recouped. E&M Procedure And Administration Procedure Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	187	Date(s) of service.		
09148	Evaluation And Management Recouped. E&M Procedure And Administration Procedure Not Allowed Same Date Of Service	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	453	Procedure Code Modifier(s) for Service(s) Rendered		
09149	Procedure Must Be Billed With The Required Evaluation And Management Or Administration Procedure Code	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	454	Procedure code for services rendered.		
09149	Procedure Must Be Billed With The Required Evaluation And Management Or Administration Procedure Code	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
09150	Administration Procedure Code Must Be Billed With Botulinum Toxin A	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M51	Missing/incomplete/invalid procedure code(s).	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09150	Administration Procedure Code Must Be Billed With Botulinum Toxin A	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N19	Procedure code incidental to primary procedure.	454	Procedure code for services rendered.		
09170	One Refraction Allowed Per Two Years For Recipients Age 21 And Older	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
09171	Only One Refraction Allowed Per Year For Recipients Under Age 21	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
09180	Diagnosis Code Is Missing Or Invalid For Lab Code. Refile With The Correct Diagnosis Code	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.		
09182	Service Denied. Maximum Units Allowed Per Week Have Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
09182	Service Denied. Maximum Units Allowed Per Week Have Been Exceeded	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	452	Total visits in total number of hours/day and total number of hours/week		
09184	Product Requires Insulin/Byetta Script Fill Within The Past 90 Days	125	Submission/billing error(s). 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.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	221	Drug days supply and dosage.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09184	Product Requires Insulin/Byetta Script Fill Within The Past 90 Days	125	Submission/billing error(s). 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.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	585	Denied Charge or Non-covered Charge		
09184	Product Requires Insulin/Byetta Script Fill Within The Past 90 Days	125	Submission/billing error(s). 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.)			N161	This drug/service/supply is covered only when the associated service is covered.	221	Drug days supply and dosage.		
09184	Product Requires Insulin/Byetta Script Fill Within The Past 90 Days	125	Submission/billing error(s). 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.)			N161	This drug/service/supply is covered only when the associated service is covered.	585	Denied Charge or Non-covered Charge		
09200	Drg - Inpatient Stay Requires Accommodation Revenue Code. Correct And Resubmit Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
09201	Drg - Admission Date And Discharge Date The Same On Inpatient Claim. Resubmit As Outpatient Services	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
09205	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). 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.)			MA30	Missing/incomplete/invalid type of bill.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09205	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). 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.)			MA30	Missing/incomplete/invalid type of bill.	228	Type of bill for UB claim		
09205	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). 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.)			MA30	Missing/incomplete/invalid type of bill.	256	DRG code(s).		
09205	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). 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.)			MA43	Missing/incomplete/invalid patient status.	21	Missing or invalid information.		
09205	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). 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.)			MA43	Missing/incomplete/invalid patient status.	228	Type of bill for UB claim		
09205	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). 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.)			MA43	Missing/incomplete/invalid patient status.	256	DRG code(s).		
09206	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). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09207	Drg - Admitting Diagnosis (Fl 76) Is Required. Correct And Resubmit Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
09207	Drg - Admitting Diagnosis (Fl 76) Is Required. Correct And Resubmit Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	488	Diagnosis code(s) for the services rendered.		
09208	Drg - Principal Diagnosis (Fl 67) Is Required Correct And Resubmit Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
09208	Drg - Principal Diagnosis (Fl 67) Is Required Correct And Resubmit Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	488	Diagnosis code(s) for the services rendered.		
09209	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09209	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.		
09209	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).		
09210	Drg - Principal Diagnosis Code (Fl 67) Is Invalid Or Requires Further Subdivision. Correct And Resubmit Claim.	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.		
09210	Drg - Principal Diagnosis Code (Fl 67) Is Invalid Or Requires Further Subdivision. Correct And Resubmit Claim.	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.		
09211	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.		
09211	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.		
09211	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).		
09212	Drg - Other Diagnosis Code 3 Is Invalid Or Requires Furthe 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.		
09212	Drg - Other Diagnosis Code 3 Is Invalid Or Requires Furthe 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.		
09212	Drg - Other Diagnosis Code 3 Is Invalid Or Requires Furthe 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).		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09213	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.		
09213	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.		
09213	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).		
09214	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.		
09214	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.		
09214	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).		
09215	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.		
09215	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.		
09215	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).		
09216	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.		
09216	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.		
09216	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).		
09217	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.		
09217	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09217	Drg - Other Diagnosis Code 8 Is Invalid Or Requires Further Subdivision. Correct And Resubmit Claim	146	Diagnosis was invalid for the date(s) of service reported.			M64	Missing/incomplete/invalid other diagnosis.	256	DRG code(s).		
09218	Drg - Other Diagnosis Code 9 Is Invalid Or Requires Further Subdivision. Correct And Resubmit Claim	146	Diagnosis was invalid for the date(s) of service reported.			M64	Missing/incomplete/invalid other diagnosis.	255	Diagnosis code.		
09218	Drg - Other Diagnosis Code 9 Is Invalid Or Requires Further Subdivision. Correct And Resubmit Claim	146	Diagnosis was invalid for the date(s) of service reported.			M64	Missing/incomplete/invalid other diagnosis.	256	DRG code(s).		
09219	Drg - Principle Dx (Fl 67) Invalid For Recipient Sex. If Mi And Dx Are Correct, Submit Claim To Dma Claims Analysis Uni See Billing Guidelines	10	The diagnosis is inconsistent with the patient's 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).		
09219	Drg - Principle Dx (Fl 67) Invalid For Recipient Sex. If Mi And Dx Are Correct, Submit Claim To Dma Claims Analysis Uni See Billing Guidelines	10	The diagnosis is inconsistent with the patient's 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.		
09220	Drg - Other Dx 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 patient's 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).		
09220	Drg - Other Dx 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 patient's 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.		
09220	Drg - Other Dx 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	256	DRG code(s).		
09220	Drg - Other Dx 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	86	Diagnosis and patient gender mismatch.		
09221	Drg - Other Dx 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 patient's 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).		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09221	Drg - Other Dx 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 patient's 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.		
09221	Drg - Other Dx 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	256	DRG code(s).		
09221	Drg - Other Dx 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	86	Diagnosis and patient gender mismatch.		
09222	Drg - Other Dx 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 patient's 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).		
09222	Drg - Other Dx 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 patient's 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.		
09222	Drg - Other Dx 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	256	DRG code(s).		
09222	Drg - Other Dx 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	86	Diagnosis and patient gender mismatch.		
09223	Drg - Other Dx 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 patient's 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).		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09223	Drg - Other Dx 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 patient's 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.		
09223	Drg - Other Dx 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	256	DRG code(s).		
09223	Drg - Other Dx 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	86	Diagnosis and patient gender mismatch.		
09224	Drg - Other Dx 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 patient's 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).		
09224	Drg - Other Dx 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 patient's 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.		
09224	Drg - Other Dx 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	256	DRG code(s).		
09224	Drg - Other Dx 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	86	Diagnosis and patient gender mismatch.		
09225	Drg - Other Dx 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 patient's 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).		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09225	Drg - Other Dx 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 patient's 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.		
09225	Drg - Other Dx 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	256	DRG code(s).		
09225	Drg - Other Dx 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	86	Diagnosis and patient gender mismatch.		
09226	Drg - Other Dx 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 patient's 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).		
09226	Drg - Other Dx 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 patient's 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.		
09226	Drg - Other Dx 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	256	DRG code(s).		
09226	Drg - Other Dx 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	86	Diagnosis and patient gender mismatch.		
09227	Drg - Other Dx Code 9 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 patient's 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).		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09227	Drg - Other Dx Code 9 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 patient's 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.		
09227	Drg - Other Dx Code 9 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	256	DRG code(s).		
09227	Drg - Other Dx Code 9 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N59	Please refer to your provider manual for additional program and provider information.	86	Diagnosis and patient gender mismatch.		
09237	Drg - Admitting Diagnosis Not Allowed For Type Of Admission	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.			MA65	Missing/incomplete/invalid admitting diagnosis.	231	Hospital admission type.		
09237	Drg - Admitting Diagnosis Not Allowed For Type Of Admission	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.			MA65	Missing/incomplete/invalid admitting diagnosis.	232	Admitting diagnosis.		
09237	Drg - Admitting Diagnosis Not Allowed For Type Of Admission	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.			MA65	Missing/incomplete/invalid admitting diagnosis.	256	DRG code(s).		
09238	Drg - Principal Diagnosis Code (Fl 67) Is The Manifestation Of An Underlying Disease Or Condition. Correct Principal D Code To The Underlying Condition And Resubmit Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09238	Drg - Principal Diagnosis Code (Fl 67) Is The Manifestation Of An Underlying Disease Or Condition. Correct Principal D Code To The Underlying Condition And Resubmit Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	488	Diagnosis code(s) for the services rendered.		
09239	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). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
09239	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). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	488	Diagnosis code(s) for the services rendered.		
09240	Drg - Principal Diagnosis Code (Fl 67) Unacceptable For Admission To Acute Care Hospital. Correct And Resubmit Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09240	Drg - Principal Diagnosis Code (Fl 67) Unacceptable For Admission To Acute Care Hospital. Correct And Resubmit Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	488	Diagnosis code(s) for the services rendered.		
09241	Drg - Principal Diagnosis (Fl 67) Unacceptable For Admission Without Additional Diagnosis. Correct And Resubmit Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
09241	Drg - Principal Diagnosis (Fl 67) Unacceptable For Admission Without Additional Diagnosis. Correct And Resubmit Claim	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	488	Diagnosis code(s) for the services rendered.		
09242	Drg - Other Diagnosis 2 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	125	Submission/billing error(s). 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.)			M64	Missing/incomplete/invalid other diagnosis.	21	Missing or invalid information.		
09242	Drg - Other Diagnosis 2 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	125	Submission/billing error(s). 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.)			M64	Missing/incomplete/invalid other diagnosis.	256	DRG code(s).		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09242	Drg - Other Diagnosis 2 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	125	Submission/billing error(s). 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.)			M64	Missing/incomplete/invalid other diagnosis.	488	Diagnosis code(s) for the services rendered.		
09243	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.		
09243	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).		
09243	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		
09244	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.		
09244	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).		
09244	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		
09245	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.		
09245	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).		
09245	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		
09246	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.		
09246	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).		
09246	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		
09247	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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09247	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).		
09247	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		
09248	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.		
09248	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).		
09248	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		
09249	Drg-Principle Procedure Invalid For Recipient Sex.If Mid An Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	7	The procedure/revenue code is inconsistent with the patient's 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.	256	DRG code(s).		
09249	Drg-Principle Procedure Invalid For Recipient Sex.If Mid An Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	7	The procedure/revenue code is inconsistent with the patient's 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.	465	Principal Procedure Code for Service(s) Rendered		
09249	Drg-Principle Procedure Invalid For Recipient Sex.If Mid An Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	256	DRG code(s).		
09249	Drg-Principle Procedure Invalid For Recipient Sex.If Mid An Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	465	Principal Procedure Code for Service(s) Rendered		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09250	Drg-Other Procedure 2 Invalid For Recipient Sex. If Mid An Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	7	The procedure/revenue code is inconsistent with the patient's 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).		
09250	Drg-Other Procedure 2 Invalid For Recipient Sex. If Mid An Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	7	The procedure/revenue code is inconsistent with the patient's 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		
09250	Drg-Other Procedure 2 Invalid For Recipient Sex. If Mid An Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	7	The procedure/revenue code is inconsistent with the patient's 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		
09250	Drg-Other Procedure 2 Invalid For Recipient Sex. If Mid An Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	256	DRG code(s).		
09250	Drg-Other Procedure 2 Invalid For Recipient Sex. If Mid An Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	474	Procedure code and patient gender mismatch		
09250	Drg-Other Procedure 2 Invalid For Recipient Sex. If Mid An Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	490	Other Procedure Code for Service(s) Rendered		
09251	Drg-Other Procedure 3 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 patient's 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).		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09251	Drg-Other Procedure 3 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 patient's 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		
09251	Drg-Other Procedure 3 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 patient's 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		
09251	Drg-Other Procedure 3 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	256	DRG code(s).		
09251	Drg-Other Procedure 3 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	474	Procedure code and patient gender mismatch		
09251	Drg-Other Procedure 3 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	490	Other Procedure Code for Service(s) Rendered		
09252	Drg-Other Procedure 4 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 patient's 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).		
09252	Drg-Other Procedure 4 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 patient's 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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09252	Drg-Other Procedure 4 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 patient's 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		
09252	Drg-Other Procedure 4 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	256	DRG code(s).		
09252	Drg-Other Procedure 4 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	474	Procedure code and patient gender mismatch		
09252	Drg-Other Procedure 4 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	490	Other Procedure Code for Service(s) Rendered		
09253	Drg-Other Procedure 5 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 patient's 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).		
09253	Drg-Other Procedure 5 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 patient's 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		
09253	Drg-Other Procedure 5 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 patient's 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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09253	Drg-Other Procedure 5 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	256	DRG code(s).		
09253	Drg-Other Procedure 5 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	474	Procedure code and patient gender mismatch		
09253	Drg-Other Procedure 5 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	490	Other Procedure Code for Service(s) Rendered		
09254	Drg-Other Procedure 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 patient's 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).		
09254	Drg-Other Procedure 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 patient's 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		
09254	Drg-Other Procedure 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 patient's 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		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09254	Drg-Other Procedure 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	256	DRG code(s).		
09254	Drg-Other Procedure 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	474	Procedure code and patient gender mismatch		
09254	Drg-Other Procedure 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 patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	490	Other Procedure Code for Service(s) Rendered		
09255	Drg-Principle Procedure Invalid For Recipient Sex.If Mid An Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	256	DRG code(s).		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09255	Drg-Principle Procedure Invalid For Recipient Sex.If Mid An Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	465	Principal Procedure Code for Service(s) Rendered		
09256	Drg - Other Diagnosis 3 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	256	DRG code(s).		
09256	Drg - Other Diagnosis 3 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	488	Diagnosis code(s) for the services rendered.		
09256	Drg - Other Diagnosis 3 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	54	Duplicate of a previously processed claim/line.		
09256	Drg - Other Diagnosis 3 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	256	DRG code(s).		
09256	Drg - Other Diagnosis 3 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered.		
09256	Drg - Other Diagnosis 3 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	54	Duplicate of a previously processed claim/line.		
09257	Drg - Other Diagnosis 4 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	256	DRG code(s).		
09257	Drg - Other Diagnosis 4 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	488	Diagnosis code(s) for the services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09257	Drg - Other Diagnosis 4 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	54	Duplicate of a previously processed claim/line.		
09257	Drg - Other Diagnosis 4 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	256	DRG code(s).		
09257	Drg - Other Diagnosis 4 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered.		
09257	Drg - Other Diagnosis 4 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	54	Duplicate of a previously processed claim/line.		
09258	Drg - Other Diagnosis 5 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	256	DRG code(s).		
09258	Drg - Other Diagnosis 5 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	488	Diagnosis code(s) for the services rendered.		
09258	Drg - Other Diagnosis 5 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	54	Duplicate of a previously processed claim/line.		
09258	Drg - Other Diagnosis 5 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	256	DRG code(s).		
09258	Drg - Other Diagnosis 5 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered.		
09258	Drg - Other Diagnosis 5 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	54	Duplicate of a previously processed claim/line.		
09259	Drg - Other Diagnosis 6 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	256	DRG code(s).		
09259	Drg - Other Diagnosis 6 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	488	Diagnosis code(s) for the services rendered.		
09259	Drg - Other Diagnosis 6 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	54	Duplicate of a previously processed claim/line.		
09259	Drg - Other Diagnosis 6 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	256	DRG code(s).		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09259	Drg - Other Diagnosis 6 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered.		
09259	Drg - Other Diagnosis 6 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	54	Duplicate of a previously processed claim/line.		
09260	Drg - Other Diagnosis 7 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	256	DRG code(s).		
09260	Drg - Other Diagnosis 7 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	488	Diagnosis code(s) for the services rendered.		
09260	Drg - Other Diagnosis 7 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	54	Duplicate of a previously processed claim/line.		
09260	Drg - Other Diagnosis 7 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	256	DRG code(s).		
09260	Drg - Other Diagnosis 7 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered.		
09260	Drg - Other Diagnosis 7 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	54	Duplicate of a previously processed claim/line.		
09261	Drg - Other Diagnosis 8 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	256	DRG code(s).		
09261	Drg - Other Diagnosis 8 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	488	Diagnosis code(s) for the services rendered.		
09261	Drg - Other Diagnosis 8 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	54	Duplicate of a previously processed claim/line.		
09261	Drg - Other Diagnosis 8 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	256	DRG code(s).		
09261	Drg - Other Diagnosis 8 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered.		
09261	Drg - Other Diagnosis 8 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	54	Duplicate of a previously processed claim/line.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09262	Drg - Other Diagnosis 9 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	256	DRG code(s).		
09262	Drg - Other Diagnosis 9 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	488	Diagnosis code(s) for the services rendered.		
09262	Drg - Other Diagnosis 9 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M64	Missing/incomplete/invalid other diagnosis.	54	Duplicate of a previously processed claim/line.		
09262	Drg - Other Diagnosis 9 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	256	DRG code(s).		
09262	Drg - Other Diagnosis 9 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	488	Diagnosis code(s) for the services rendered.		
09262	Drg - Other Diagnosis 9 Is Duplicate Of Principal Diagnosis Correct And Resubmit Claim	18	Exact duplicate claim/service (Use only with Group Code OA)			M76	Missing/incomplete/invalid diagnosis or condition.	54	Duplicate of a previously processed claim/line.		
09263	Drg - Bilateral Procedure 2: Please Attach Operative Record And Submit Claim As An Adjustment	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	256	DRG code(s).		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09263	Drg - Bilateral Procedure 2: Please Attach Operative Record And Submit Claim As An Adjustment	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	298	Operative report.		
09263	Drg - Bilateral Procedure 2: Please Attach Operative Record And Submit Claim As An Adjustment	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09263	Drg - Bilateral Procedure 2: Please Attach Operative Record And Submit Claim As An Adjustment	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	256	DRG code(s).		
09263	Drg - Bilateral Procedure 2: Please Attach Operative Record And Submit Claim As An Adjustment	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	298	Operative report.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09263	Drg - Bilateral Procedure 2: Please Attach Operative Record And Submit Claim As An Adjustment	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	454	Procedure code for services rendered.		
09264	Drg-Other Procedure 3 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	256	DRG code(s).		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09264	Drg-Other Procedure 3 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	298	Operative report.		
09264	Drg-Other Procedure 3 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09264	Drg-Other Procedure 3 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	256	DRG code(s).		
09264	Drg-Other Procedure 3 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	298	Operative report.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09264	Drg-Other Procedure 3 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	454	Procedure code for services rendered.		
09265	Drg-Other Procedure 4 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	256	DRG code(s).		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09265	Drg-Other Procedure 4 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	298	Operative report.		
09265	Drg-Other Procedure 4 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09265	Drg-Other Procedure 4 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	256	DRG code(s).		
09265	Drg-Other Procedure 4 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	298	Operative report.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09265	Drg-Other Procedure 4 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	454	Procedure code for services rendered.		
09266	Drg-Other Procedure 5 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	256	DRG code(s).		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09266	Drg-Other Procedure 5 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	298	Operative report.		
09266	Drg-Other Procedure 5 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09266	Drg-Other Procedure 5 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	256	DRG code(s).		
09266	Drg-Other Procedure 5 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	298	Operative report.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09266	Drg-Other Procedure 5 Invalid For Recipient Sex. If Mid And Icd-9 Px Are Correct, Submit Claim To Dma Claims Analysis Unit, See Billing Guidelines	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	454	Procedure code for services rendered.		
09267	Drg-Bilateral Procedure 6: Please Attached Operative Record And Submit Claim As An Adjustment	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	256	DRG code(s).		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09267	Drg-Bilateral Procedure 6: Please Attached Operative Record And Submit Claim As An Adjustment	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	298	Operative report.		
09267	Drg-Bilateral Procedure 6: Please Attached Operative Record And Submit Claim As An Adjustment	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M29	Missing operative note/report.	454	Procedure code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09267	Drg-Bilateral Procedure 6: Please Attached Operative Record And Submit Claim As An Adjustment	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	256	DRG code(s).		
09267	Drg-Bilateral Procedure 6: Please Attached Operative Record And Submit Claim As An Adjustment	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	298	Operative report.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09267	Drg-Bilateral Procedure 6: Please Attached Operative Record And Submit Claim As An Adjustment	16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	454	Procedure code for services rendered.		
09269	Drg - Admission Hour And Discharge Hour Are Invalid (Not 00 Through 23). Correct And Resubmit Claim	125	Submission/billing error(s). 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.)			N46	Missing/incomplete/invalid admission hour.	21	Missing or invalid information.		
09269	Drg - Admission Hour And Discharge Hour Are Invalid (Not 00 Through 23). Correct And Resubmit Claim	125	Submission/billing error(s). 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.)			N46	Missing/incomplete/invalid admission hour.	230	Hospital admission hour.		
09269	Drg - Admission Hour And Discharge Hour Are Invalid (Not 00 Through 23). Correct And Resubmit Claim	125	Submission/billing error(s). 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.)			N46	Missing/incomplete/invalid admission hour.	233	Hospital discharge hour.		
09269	Drg - Admission Hour And Discharge Hour Are Invalid (Not 00 Through 23). Correct And Resubmit Claim	125	Submission/billing error(s). 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.)			N50	Missing/incomplete/invalid discharge information.	21	Missing or invalid information.		
09269	Drg - Admission Hour And Discharge Hour Are Invalid (Not 00 Through 23). Correct And Resubmit Claim	125	Submission/billing error(s). 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.)			N50	Missing/incomplete/invalid discharge information.	230	Hospital admission hour.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09269	Drg - Admission Hour And Discharge Hour Are Invalid (Not 00 Through 23). Correct And Resubmit Claim	125	Submission/billing error(s). 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.)			N50	Missing/incomplete/invalid discharge information.	233	Hospital discharge hour.		
09271	Payment Included In Drg Reimbursement On First Accommodatio Detail	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			M50	Missing/incomplete/invalid revenue code(s).	256	DRG code(s).		
09271	Payment Included In Drg Reimbursement On First Accommodatio Detail	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			M50	Missing/incomplete/invalid revenue code(s).	455	Revenue code for services rendered.		
09271	Payment Included In Drg Reimbursement On First Accommodatio Detail	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			M50	Missing/incomplete/invalid revenue code(s).	65	Claim/line has been paid.		
09273	No Drg Rcc Code Segment On File For Provider Number 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).		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09275	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.		
09275	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.		
09278	Units Cutback To Allowed Amount. Drug Limited To 210 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.		
09278	Units Cutback To Allowed Amount. Drug Limited To 210 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.		
09291	Provider Must Rebill After Dates Of Service Have Met The 60 Day Interval	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/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.		
09293	Drg - Most Current Services Already Received	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.					256	DRG code(s).		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09294	Drg Recoupment	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			MA67	Correction to a prior claim.	101	Claim was processed as adjustment to previous claim.		
09294	Drg Recoupment	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)			MA67	Correction to a prior claim.	256	DRG code(s).		
09300	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. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M20	Missing/incomplete/invalid HCPCS.	455	Revenue code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09300	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. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M20	Missing/incomplete/invalid HCPCS.	507	HCPCS		
09300	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. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N142	The original claim was denied. Resubmit a new claim, not a replacement claim.	455	Revenue code for services rendered.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09300	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. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N142	The original claim was denied. Resubmit a new claim, not a replacement claim.	507	HCPCS		
09301	Exceeds Maximum Units Allowed Per 84 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
09401	Units Cutback. Exceeds Maximum Units Allowed Per 84 Days	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
09491	Only One Sexually Transmitted Infection Treatment Allowed Per Calendar Year For Family Planning Waiver Recipients	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					454	Procedure code for services rendered.		
09491	Only One Sexually Transmitted Infection Treatment Allowed Per Calendar Year For Family Planning Waiver Recipients	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					585	Denied Charge or Non-covered Charge		
09506	Ndc Drug Class (Gc3) Must Match Gc3 Of Procedure Code Billed	181	Procedure code was invalid on the date of service.	CO	Contractual Obligations	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	218	NDC number.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09519	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. 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.)			M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	21	Missing or invalid information.		
09519	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. 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.)			M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	454	Procedure code for services rendered.		
09519	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. 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.)			M70	Alert: The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	21	Missing or invalid information.		
09519	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. 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.)			M70	Alert: The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	454	Procedure code for services rendered.		
09612	Adult Care Home Services Are Not Allowed When Client Is In- Patient (Acute Or Ltc Facility). Correct And Resubmit For Service Dates Client Was Not Hospitalized	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	21	Missing or invalid information.		
09618	One Evaluation Allowed Per Calendar Year	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09703	Occupational Therapy Re-Evaluation Not Allowed Same Day As Occupational Therapy Evaluation	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
09704	Occupational Therapy Evaluation Not Allowed Same Day As Occupational Therapy Re-Evaluation	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			N20	Service not payable with other service rendered on the same date.	258	Days/units for procedure/revenue code.		
09800	Claim Denied. Follow-Up Care Is Included In Radiation Management	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 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.		
09803	Medicare Claim Denied As Duplicate, Resubmit With Medicare Eomb That Shows Payment For Dates Of Service Listed	18	Exact duplicate claim/service (Use only with Group Code OA)			M86	Service denied because payment already made for same/similar procedure within set time frame.	54	Duplicate of a previously processed claim/line.		
09810	Service Recouped. Radiation Management Paid Included Follow-Up Care	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M80	Not covered when performed during the same session/date as a previously processed service for the patient.	454	Procedure code for services rendered.		
09820	Invalid Coordination Of Benefits Other Payer Id Qualifier. Valid Qualifiers Are: 01 Through 04, 09, 99 Or Blank	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					21	Missing or invalid information.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09821	Invalid Coordination Of Benefits Reject Count. Must Be 01 Through 05	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)					21	Missing or invalid information.		
09825	Exceeds Legislative Limits For Provider Visits For Fiscal Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		
09825	Exceeds Legislative Limits For Provider Visits For Fiscal Year	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	263	Length of time for services rendered.		
09862	Units Cutback To Allowed Amount. Drug Limited To 1800 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.		
09862	Units Cutback To Allowed Amount. Drug Limited To 1800 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.		
09865	Only One Influenza Procedure Allowed Per Same Date Of Service	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
09872	Only Two Units Of Influenza Procedures Allowed Within 240 Days	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	258	Days/units for procedure/revenue code.		
09872	Only Two Units Of Influenza Procedures Allowed Within 240 Days	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
09874	Claim Denied. A Meningococcal Vaccine Has Already Been Paid To A 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.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09898	Service Denied Due To Lack Of Required Documentation. Send Required Documentation To Pre-Pay Review Contractor And Resubmit Claim To Fiscal Agent	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N35	Program integrity/utilization review decision.	294	Supporting documentation.		
09905	Patient Is Enrolled In A Hmo Plan. Delivery Charges Have Been Made To The Hmo. Physicians May Bill Fee For Service For Care Rendered On Out-Of-Plan Dates Of Service	24	Charges are covered under a capitation agreement/managed care plan.					96	No agreement with entity.	1E	HEALTH MAINTENANCE ORGANIZATION (HMO)
09906	Patient Is Enrolled In A Hmo Plan. Delivery Charges Have Been Made To The Hmo. Physicians May Bill Fee For Service For Care Rendered On Out-Of-Plan Dates Of Service	24	Charges are covered under a capitation agreement/managed care plan.					96	No agreement with entity.	1E	HEALTH MAINTENANCE ORGANIZATION (HMO)
09940	Tenth Ndc Is Desi (Less-Than-Effective)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision .	218	NDC number.		
09940	Tenth Ndc Is Desi (Less-Than-Effective)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision .	454	Procedure code for services rendered.		
09951	Tenth Ndc Is Non-Covered Either By Dma Policy Or Cms Mandated	96	Non-covered charge(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision .	218	NDC number.		
09951	Tenth Ndc Is Non-Covered Either By Dma Policy Or Cms Mandated	96	Non-covered charge(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision .	585	Denied Charge or Non-covered Charge		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09952	Ndc Is Desi (Less-Than-Effective)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	218	NDC number.		
09952	Ndc Is Desi (Less-Than-Effective)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	454	Procedure code for services rendered.		
09972	Over The Counter Drugs (Except Insulin) Are Not Paid For Long Term Care (Snf Only) Recipients	96	Non-covered charge(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	585	Denied Charge or Non-covered Charge		
09972	Over The Counter Drugs (Except Insulin) Are Not Paid For Long Term Care (Snf Only) Recipients	96	Non-covered charge(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.			M79	Missing/incomplete/invalid charge.	585	Denied Charge or Non-covered Charge		
09973	Levulan Kerastick 1 Stick Equals 1 Unit. Medicaid Allows 2 Units Within 8 Weeks. Units Cutback To Maximum Allowable	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	259	Frequency of service.		
09973	Levulan Kerastick 1 Stick Equals 1 Unit. Medicaid Allows 2 Units Within 8 Weeks. Units Cutback To Maximum Allowable	119	Benefit maximum for this time period or occurrence has been reached.			M86	Service denied because payment already made for same/similar procedure within set time frame.	483	Maximum coverage amount met or exceeded for benefit period.		
09973	Levulan Kerastick 1 Stick Equals 1 Unit. Medicaid Allows 2 Units Within 8 Weeks. Units Cutback To Maximum Allowable	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	259	Frequency of service.		

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ADJUSTMENT REASON CODE DESCRIPTION	HIPAA GROUP CODE	HIPAA GROUP CODE DESCRIPTION	HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION	HIPAA CLAIMS STATUS CODE	HIPAA CLAIMS STATUS CODE DESCRIPTION	ENTITY ID	ENTITY DESCRIPTION
09973	Levulan Kerastick 1 Stick Equals 1 Unit. Medicaid Allows 2 Units Within 8 Weeks. Units Cutback To Maximum Allowable	119	Benefit maximum for this time period or occurrence has been reached.			N362	The number of Days or Units of Service exceeds our acceptable maximum.	483	Maximum coverage amount met or exceeded for benefit period.		
09992	Ndc Missing. Verify And Enter The Correct Ndc And Submit A New Claim	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	218	NDC number.		
09992	Ndc Missing. Verify And Enter The Correct Ndc And Submit A New Claim	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)			N142	The original claim was denied. Resubmit a new claim, not a replacement claim.	218	NDC number.		
49270	Ncci Physician Edit										
49280	Ncci Outpatient Hospital Services Edit										
49480	Medical/Pharmacy Dupe, Same Ndc Or Gcn Cd										