EOB	EOB_Message
1	PROVIDER TYPE INCONSISTENT WITH CLAIM TYPE
2	RECIPIENT INELIGIBLE FOR DATES OF SERVICE
3	PAYMENT FOR SERVICE INCLUDED IN ENCOUNTER RATE
4	MUST BILL CLAIM USING PATIENT MID, NOT HEAD OF HOUSEHOLD MID
5	YOUR CLAIM WAS GIVEN INDIVIDUAL CONSIDERATION AND REIMBURSED ACCORDINGLY
6	PROVIDER NUMBER HAS NOT BEEN RENEWED. CONTACT EDS ENROLLMENT FOR ASSISTANCE
7	PLEASE RESUBMIT CLAIM ACCORDING TO NEW AMBULANCE BILLING GUIDELINES
8	RECIPIENT NUMBER MISSING/INVALID/NOT ON FILE
9	RECIPIENT NAME/NUMBER MISMATCH/MISSING/INVALID
10	RECIPIENT INELIGIBLE FOR DATE OF SERVICE BILLED/UNKNOWN TO INRHODES
11	CLAIM DENIED. PROVIDER NAME/NUMBER ON CLAIM DOESN"T MATCH OUR FILES
12	NO PRICE ON FILE FOR REVENUE CODE
13	INDIVIDUAL CHARGE IS MISSING OR NOT EQUAL TO THE SUM OF THE DETAILS
14	OTHER INSURANCE INDICATOR MISSING/INVALID
15	PAYMENT REDUCED TO SPENDDOWN AMOUNT
16	YOUR CLAIM WAS REVIEWED BY DHS. YOUR COVERAGE WAS STILL IN EFFECT
17	NET CHARGE MISSING/INVALID
18	REFERRING PHYSICIAN INFORMATION REQUIRED AND NOT PRESENT
19	CLAIM DENIED. AMBULANCE CERTIFICATION INCOMPLETE. PLEASE CORRECT AND RESUBMIT
20	CLAIM DENIED. DOES NOT WARRANT AMBULANCE USE
21	INITIAL TEN (10) AMBULANCE MILEAGE INCLUDED IN BASE CODE
22	PRIMARY DIAGNOSIS MISSING/INVALID
23	PRO SIGNATURE MISSING
24	ANESTHESIA CLAIM DENIED. CAN NOT PAY UNTIL SUBMISSION & PMT OF PHYSICIAN CLAIM.
25	ATTENDING/PERFORMING PROVIDER NUMBER MISSING OR INVALID
26	SURGICAL DATE IS MISSING OR INVALID
27	2ND SURGICAL PROCEDURE DATE IS MISSING/INVALID/ILLOGICAL
28	3RD SURGICAL PROCEDURE DATE MISSING/INVALID/ILLOGICAL
29	PRIMARY SURGICAL DATE MISSING/INVALID/ILLOGICAL
30	PROVIDER INACTIVE ON DATE OF SERVICE
31	PLEASE RESUBMIT ON APPROPRIATE CLAIM FORM
32	TYPE OF BILL MISSING OR INVALID
33	PAYMENT OF THIS DETAIL CONSIDERED ON FIRST LINE WITH THIS DATE OF SERVICE BILLED
34	ADMISSION DATE MISSING/INVALID/ILLOGICAL
35	THE ADMISSION DATE IS LATER THAN THE FROM AND/OR THROUGH DATE OF SERVICE
36	INAPPROPRIATE CODE. REFER TO YOUR CURRENT DENTAL LIST
37	ADMISSION CODE DOES NOT WARRANT EMERGENCY ROOM SERVICE
38	CLAIM PAST 365 DAY FILING LIMIT
39	SECOND DIAGNOSIS NOT ON FILE OR INVALID
40	CLAIM DENIED. ATTACHMENTS ARE INVALID AND/OR ILLEGIBLE
41	DISPENSED DATE OR FROM DATE OF SERVICE MISSING/INVALID
42	PATIENT STATUS CODE IS MISSING/INVALID
43	ADMISSION CODE MISSING/INVALID
44	SERVICES CAN"T BE BILLED PRIOR TO DATE PERFORMED
45	THE DISCHARGE/THROUGH DATE OF SERVICE IS MISSING/INVALID
46	THE THROUGH/DISCHARGE DATE OF SERVICE IS MISSING/INVALID
47	NDC IS MISSING OR INVALID
48	INAPPROPRIATE PROCEDURE CODE. PLEASE REFER TO YOUR CURRENT MANUAL

49	CLAIM DENIED; PROCEDURE CODE BILLED MUST MATCH PA APPROVAL
50	INAPPROPRIATE BILLING OF MULTIPLE PROCEDURE CODES, PLEASE ADD MODIFIER 51.
51	PROCEDURE CODE IS NOT VALID FOR DOS BILLED
52	PLEASE DOCUMENT LENS PROVIDER, TYPE OF LENS, AND PRICE OF LENS
53	DATE OF SERVICE REQUIRED FOR EACH LINE BILLED
54	THIS CODE HAS BEEN DELETED BY HCPCS. REFER TO CURRENT MANUALS
55	THE THRU DATE OF SERVICE IS BEFORE THE FROM DATE OF SERVICE
56	DOCUMENTATION NEEDED SUBSTANTIATING NUMBER OF UNITS BILLED
57	BILL CODE ONCE ONLY WITH TOTAL NUMBER OF UNITS. INCLUDE OP NOTES AND/OR EXPLAIN
58	QUANTITY OR UNITS MISSING/INVALID
59	NOTICE OF DECISION SPENDDOWN AMOUNT ATTACHMENT MISSING OR INVALID
60	DETAIL CHARGE IS MISSING OR INVALID
61	NO PAYMENT DUE. SPENDDOWN GREATER THAN OR EQUAL TO ALLOWED AMMOUNT
62	INCORRECT BILLING OF SPENDDOWN ACCORDING TO INSTRUCTIONS
63	THIS SERVICE REQUIRES PRIOR AUTHORIZATION
64	REVENUE CODE DOES NOT MATCH DESCRIPTION PROVIDED
65	THE PLACE OF SERVICE CODE IS INVALID OR MISSING FOR THIS PROCEDURE
66	CLAIM CURRENTLY IN PROCESS. DO NOT RESUBMIT
67	PROCEDURE CODE MISSING OR INVALID
68	NDC NOT ON FILE OR DESCRIPTION IS MISSING/INVALID
69	NDC/PROCEDURE DOES NOT MATCH DESCRIPTION PROVIDED
70	METRIC QUANTITY MISSING/INVALID
71	THIS DIAGNOSIS REQUIRES PRIOR AUTHORIZATION
72	DISPENSING DATE MISSING/INVALID
73	ESTIMATED DAYS SUPPLY MISSING OR INVALID
74	DETAIL DENIED, SERVICE INCLUDED IN OFFICE VISIT
75	PORTABLE SITZ BATH LIMITED TO ONE PER LIFETIME
76	CLAIM/DETAIL DENIED. DME PURCHASE PRICE HAS BEEN REACHED
77	REFILL INDICATOR IS MISSING OR INVALID
78	ADJUSTMENT RESULTED IN REDUCED PAYMENT. ACCOUNTS RECEIVABLE SET UP FOR RESIDUAL
79	RI MEDICAL ASSISTANCE HAS A UNIQUE PROCEDURE CODE FOR THIS SERVICE
80	MEDICAL NECESSITY FORM INCOMPLETE/OUT OF DATE
81	MEDICAL NECESSITY FORM GREATER THAN 6 MONTHS OLD
82	THIS PAYMENT IS THE RESULT OF AN ADJUSTMENT REQUEST
83	THIS RECOUPMENT IS THE RESULT OF AN ADJUSTMENT REQUEST.
84	THIS AMOUNT WITHHELD AS A RESULT OF AN OUTSTANDING RECEIVABLE
85	THIS CREDIT TRANSACTION IS THE RESULT OF YOUR REFUND REQUEST.
86	DETAIL DENIED: CONSIDERED INCLUDED IN A PREVIOUSLY BILLED SERVICE
87	THIS CREDIT TRANSACTION IS THE RESULT OF AN EDS CHECK ISSUED TO YOU IN ERROR
88	PLEASE SUBMIT THIS CLAIM AS AN ADJUSTMENT
89	CLAIM DENIED. DISPENSED AS WRITTEN MUST BE Y OR N
90	CLAIM/DETAIL DENIED. NO PAYMENT DUE WHEN RECIPIENT PAYS CHARGE
91	SERVICE DENIED; NOT COVERED BY RHODE ISLAND MEDICAL ASSISTANCE PROGRAM
92	IN ADDITION TO ENCOUNTER DETAIL MUST ZERO BILL A DETAIL FOR EACH PROC PERFORMED
93	PAYMENT AMOUNT REDUCED TO MAXIMUM ALLOWABLE AMOUNT
94	CLAIM DENIED. A PORTION OF THESE DAYS WERE PAID AS AN INPATIENT
95	CLAIM CUTBACK DUE TO OTHER INSURANCE PAYMENT
96	CLAIM DENIED. EXACT DUPLICATE OF SERVICE PREVIOUSLY PAID, OR CURRENTLY SUSPENDED
97	REIMBURSEMENT FOR ANCILLARY CHARGES INCLUDED IN INPATIENT/PER DIEM RATE

98	THIS AMOUNT HAS BEEN APPLIED TO AN OUTSTANDING ACCOUNTS RECEIVABLE
99	PAYMENT REDUCED BY APPLIED INCOME AMOUNT
100	CLAIM RETURNED - PROVIDER SIGNATURE MISSING/INVALID
101	PROVIDER NAME MISSING/INVALID/MISSPELLED
102	CLAIM IS ILLEGIBLE. PLEASE RESUBMIT A LEGIBLE FORM
103	CLAIM (DETAIL) DENIED. ATTACHMENT DOES NOT MATCH THE CLAIM
104	CLAIM DENIED. NO COINSURANCE OR DEDUCTIBLE DUE
105	NO PAYMENT DUE. OTHER INSURANCE AMOUNT GREATER THAN OR EQUAL TO ALLOWED AMOUNT
106	NDC NOT FOUND PLEASE CHECK FOR CORRECT CODE/DESCRIPTION RESUBMIT W/DOCUMENTATION
107	CLAIM SUBMITTED WITHOUT ANY SERVICES BILLED
108	REVENUE CODE IS MISSING OR INVALID
109	INVALID REVENUE CODE FOR DIALYSIS CROSSOVER CLAIM
110	MEDICARE BENEFITS SHEET ILLEGIBLE. PLEASE RESUBMIT WITH LEGIBLE COPY
111	DEDUCTIBLE NON-COVERED. RECIPIENT IS INELIGIBLE ON THE FIRST DATE OF SERVICE
112	ATTENDING/PERFORMING PROVIDER INELIGIBLE ON DATE OF SERVICE
113	MEDICARE BENEFITS SHEET DOES NOT MATCH CLAIM
114	NURSE PRACTITIONER CANNOT BE BILLING PROVIDER
115	PLEASE RESUBMIT WITH ENTIRE PAGE OF MEDICARE EOMB/RA TO SHOW PAYMENT DATE
116	NO CROSSOVER PAYMENT DUE. OTHER PAYMENT GREATER OR EQUAL TO ALLOWED AMOUNT
117	ATTENDING/PERFORMING PROVIDER MISSING/NOT ON FILE/INVALID
118	SURGICAL PROCEDURE CODE MISSING OR INVALID. RESUBMIT W/CORRECT ICD-9 PROC CODE
119	DIAGNOSTIC AND NON-SURGICAL PROCEDURE CODES NOT ALLOWED ON UB82/92 BILLING
120	PRO INDICATOR MUST BE A 1, 2, OR 5
121	PRO FROM DATE IS AFTER THE FDOS. PLEASE DELETE NON PRO DATES AND CHARGES
122	PRO DATES ARE MISSING OR INVALID
123	ACCIDENT/OCCURRENCE/EMPLOYMENT INDICATOR MISSING/INVALID
124	ACCORDING TO OUR RECORDS THIS NDC IS NO LONGER ACTIVE
125	ACCIDENT/OCCURRENCE DATE MISSING OR INVALID
126	NDC BEING BILLED HAS BEEN DELETED BY DHS
127	YOUR SUBMITTED CLAIM"S RA DATE/CLAIM INFORMATION IS MISSING OR INELIGIBLE
128	CONDITION/EMPLOYMENT INDICATOR MISSING/INVALID
129	SURGICAL PROCEDURE CODES MUST BE BILLED IN DATE ORDER SEQUENCE
130	CAST REMOVAL CODES CAN BE BILLED ONLY FOR CASTS APPLIED BY ANOTHER MD/MD GROUP
131	DETAIL DENIED. CAST APPLICATION INCLUDED IN INITIAL CARE
132	EPSDT INDICATOR INVALID. PLEASE CORRECT AND RESUBMIT
133	MEDICAID DOES NOT PAY PHYSICIAN FOR CAST MATERIALS WHEN APPLIED POS 1 OR 2
134	PAYMENT REDUCED TO DRUG UCR AMOUNT
135	PAYMENT DENIED: LOADING FEE CAP HAS BEEN REACHED
136	PHYSICIAN"S AUTHORIZATION MUST BE WITHIN 6 MONTHS OF DATE OF SERVICE
137	REVIEW AWAITING DRG PRICING FROM HOSPITAL. INVOLVED CLAIM WILL BE RESUBMITTED
138	INPATIENT STAY PRICED ACCORDING TO DRG DIAGNOSIS
139	SPENDDOWN BILLED CORRECTLY. NO PAYMENT DUE
140	ONLY REVENUE CODES 300 OR 310 ARE ALLOWED ON OUTPATIENT CLAIMS WHEN BILLING LAB
141	OUTPATIENT ASC/LAB/RADIOLOGY SERVICES REQUIRE REVENUE AND HCPCS CODES
142	INAPPROPRIATE REVENUE CODE FOR SERVICES RENDERED. REFER TO YOUR LIST OF CODES
143	REIMBURSEMENT FOR ANCILLARY CHARGES INCLUDED IN %/PER DIEM RATE FOR BIRTH ROOM
144	TIME/UNITS EXCEED(S) THE NORM. PLEASE RESUBMIT WITH EXPLANATION OR DOCUMENTATION
145	NON-INJECTED MEDS ADMINISTERED IN THE OFFICE REQUIRE OFFICE NOTES AND INVOICE
146	CLAIM PAYMENT AMOUNT REDUCED BY REQUIRED CO-PAY

147	PRO CERTIFICATION ATTACHMENT REQUIRED
148	PRO CERTIFICATION FORM IS INCOMPLETE
149	FOURTH DIAGNOSIS NOT ON FILE OR IS INVALID
150	THIRD DIAGNOSIS NOT ON FILE OR IS INVALID
151	FIFTH DIAGNOSIS CODE NOT ON FILE OR IS INVALID
152	THIS ABORTION-RELATED SERVICE HAS BEEN FORWARDED TO DHS FOR PROCESSING/PAYMENT
153	REBILL ABORTION RELATED SERVICES SEPARATELY
154	ABORTION CERTIFICATION FORM REQUIRED FOR PAYMENT
155	NON-URGENT SERVICE. RECIPIENT SHOULD BE REFERRED TO IN-STATE FACILITY
156	DIAGNOSIS DESCRIPTION ON MEDICARE EOMB NOT THE SAME AS ON CLAIM
157	OBSERVATION ROOM SVCS PAID AT PER/DIEM OR PERCENTAGE RATES INCLUDE ANCILLARIES
158	PRO CERT APPROVAL FOR INPATIENT. PAYMENT REDUCED TO %/PER DIEM RATE
159	PRIOR AUTHORIZATION FROM DHS WAS REQUIRED ON THIS DATE OF SERVICE
160	THIS MANUFACTURER"S NUMBER IS OBSOLETE
161	DRUG REFILLS LIMITED TO 5 PER PRESCRIPTION
162	SEALANTS ARE NOT COVERED AFTER A RESTORATION OF THE OCCLUSAL SURFACE
163	TOOTH NUMBER IS MISSING OR INVALID FOR PROCEDURE BILLED
164	REFILL NUMBER BILLED EXCEEDS NDC REFILL LIMITATION
165	THE TOOTH SURFACE CODE IS MISSING OR INVALID
166	PROVIDER INELIGIBLE FOR DATE OF SERVICE BILLED OR SERVICE PRIOR TO CUTOVER DATE
167	REIMBURSEMENT FOR THIS SERVICE IS CONSIDERED AS PART OF YOUR %/PER DIEM RATE
168	EPSDT/FAMILY PLANNING INDICATOR MISSING OR INVALID
169	PRESCRIPTION NUMBER MISSING OR INVALID
170	INAPPROPRIATE OR INVALID MANUFACTURER NUMBER. REBILL USING CORRECT NUMBER
171	NICU PROCEDURE CODE MUST BE BILLED ON FIRST DETAIL ONLY
172	NOT A VALID NDC FOR DATE OF SERVICE BILLED
173	SERVICE DENIED. DETERMINED NOT TO BE MEDICALLY NECESSARY BY DHS
174	CLAIM DENIED. YOUR 2 MONTH SUPPLY OF NICORETTE HAS BEEN MET
175	PRIOR AUTHORIZATION NUMBER/ATTACHMENT IS NOT ADEQUATE FOR ALL SERVICES BILLED
176	THIS SERVICE IS AN EXACT DUPLICATE PER RX NUMBER AND REFILL NUMBER
177	AS OF DATE OF SERVICE 7/1/91 SERVICE CLASSIFIED AS FQHC. USE LOCAL PROC CODE
178	PLEASE SPECIFY IF SERVICE WAS IMPLANTATION OR REMOVAL OF SYSTEM
179	NEWBORN CLAIMS MUST BE SUBMITTED USING MOTHER"S MEDICAL ASSISTANCE ID
180	TOTAL DAYS BILLED ARE NOT EQUAL TO TOTAL ELAPSED DAYS
181	SERVICE DENIED. DHS/PRO REVIEW INDICATES PRE-CERTIFICATION NOT MET
182	IF DEA ST ONLY FND RECIP NEED PA FOR DAY/HOME CARE
183	NICU REVENUE CODE MUST BE BILLED ON FIRST DETAIL ONLY
184	PROVIDER NUMBER NOT CERTIFIED FOR THIS TIME PERIOD
185	CLIENT NOT AUTHORIZED AS HIGH ACUITY FOR DOS
186	LEA ALLOWED AMOUNT MODIFIED TO REFLECT FEDERAL SHARE ONLY
188	SURGICAL DATE OF SERVIE IS INVALID AND/OR DOES NOT MATCH NOTES
189	HOME HEALTH AIDE SERVICES MUST BE MINIMUM OF ONE HOUR PER DOS
190	REFERRED TO PHYSICIAN MISSING/INVALID
192	OTHER INSURANCE DOCUMENT REVIEWED AND DENIED BY DHS
193	OTHER INSURANCE DOCUMENT REVIEWED AND APPROVED
194	PAYMENT HAS BEEN RECEIVED BY CLIENT OR ABSENT PARENT FOR THIS SERVICE
195	CLAIM CUTBACK DUE TO MEDICARE PAYMENT
196	NDC IS OBSOLETE
197	DIAGNOSIS CODES MUST BE SUBMITTED WITHOUT DECIMAL POINTS

198	DESI DRUG NOT COVERED
199	PAYMENT DENIED. SECONDARY SURGERY INCIDENTAL TO PRIMARY SURGERY
200	PODIATRY SERVICES NOT ALLOWED FOR MEDICALLY NEEDY RECIPIENTS
201	MANUFACTURER DID NOT SIGN REBATE AGREEMENT
202	MEDICARE PAID AMOUNT ON EOMB IS MISSING OR ILLEGIBLE
203	FUNDING SOURCE/ELIGIBILITY OVERLAP. RESUBMIT AS SEPARATE CLAIMS PER SERVICE
204	NON-MAINTENANCE DRUGS CANNOT HAVE DAYS SUPPLY GREATER THAN 30
205	BILL SAME REVENUE CODE ONLY ONCE AND INCLUDE ALL SERVICES
206	PRODUCT HAS BEEN REMOVED FROM THE MARKET
207	NATIONAL DRUG CODE NOT COVERED FOR NURSING HOME RECIPIENTS
208	DME PROCEDURE NOT ALLOWED FOR NURSING HOME RECIPIENT
209	SERVICE DENIED. NOT COVERED BY RI MEDICAL ASSISTANCE WHEN BILLED AS A CROSSOVER
210	WHEN BILLING FOR NONCONSECUTIVE DAYS, BILL SEPARATE ENCOUNTER CODES
211	WHEN BILLING FOR NONCONSECUTIVE DAYS, BILL EACH DATE SEPARATELY
212	THIS SERVICE REQUIRES A MODIFIER
213	CUTBACK FOR GPA SERVICES
214	RECIPIENT DATE OF BIRTH IS MISSING OR INVALID
215	CLAIM PAID AMOUNT GREATER THAN ALLOWED AMOUNT DUE TO PAYMENT POLICY
216	RECIPIENT DATE OF BIRTH DOES NOT MATCH OUR FILE
217	CLAIM DENIED DUE TO CLAIM CORRECTION FORM NOT RETURNED OR CCF INFO INVALID
218	SIXTH DIAGNOSIS CODE IS NOT CONSISTENT WITH THE AGE/SEX OF RECIPIENT
219	SEVENTH DIAGNOSIS CODE IS NOT CONSISTENT WITH AGE/SEX OF RECIPIENT
220	EIGHTH DIAGNOSIS CODE IS NOT CONSISTENT WITH THE AGE/SEX OF RECIPIENT
221	NINTH DIAGNOSIS CODE IS NOT CONSISTENT WITH THE AGE/SEX OF RECIPIENT
222	SIXTH DIAGNOSIS CODE NOT ON FILE OR IS INVALID
223	THIRD DIAGNOSIS CODE IS NOT CONSISTENT WITH THE AGE/SEX OF RECIPIENT
224	SEVENTH DIAGNOSIS CODE NOT ON FILE OR IS INVALID
225	FOURTH DIAGNOSIS CODE IS NOT CONSISTENT WITH THE AGE/SEX OF RECIPIENT
226	FIFTH DIAGNOSIS CODE IS NOT CONSISTENT WITH THE AGE/SEX OF RECIPIENT
227	ATTENDING/PERFORMING PROVIDER IS NOT ELIGIBLE MEMBER OF BILLING GROUP
228	EIGHTH DIAGNOSIS CODE NOT ON FILE OR IS INVALID
229	NINTH DIAGNOSIS CODE NOT ON FILE OR IS INVALID
230	SERVICE NOT COVERED FOR THIS RECIPIENT
231	DME NOT COVERED WHEN BILLED INPATIENT/OUTPATIENT
232	PHYSICAL THERAPY/CHIROPRACTIC SERVICES NOT COVERED WHEN POS INPATIENT/OUTPATIENT
233	CLAIM PAYMENT REDUCED BY COSTSHARE AMOUNT
234	SUPPLIES AND MATERIALS NOT COVERED WHEN POS INPATIENT/OURPATIENT
235	PLACE OF SERVICE REQUIRES A MODIFIER.
236	LAB SPECIALTY ONLY PAID FOR CYTOLOGY/PATHOLOGY WHEN POS INPATIENT/OUTPATIENT
237	FOURTH SURGICAL PROCEDURE DATE IS MISSING/INVALID/ILLOGICAL
238	FIFTH SURGICAL PROCEDURE DATE IS MISSING/INVALID/ILLOGICAL
239	SIXTH SURGICAL PROCEDURE DATE IS MISSING/INVALID/ILLOGICAL
240	CLAIM DENIED FOR LOCAL PROCEDURE CODE. RESUBMIT W/EQUIVELENT NAT"L PROCEDURE CODE
241	CLAIM SUSPENDED - PROGRAM INDICATOR BLANK - HEADER
242	PLEASE CLARIFY INVOICE TO EXPLAIN BILLED AMOUNT
243	CLAIM SUSPENDED - PROGRAM INDICATOR BLANK - DETAIL
244	PROGRAM INFORMATION MISSING FOR DRUG
245	AMBULANCE CERTIFICATION FORM MUST STATE ORIGIN AND DESTINATION OF AMBULANCE
246	AMBULANCE CERTIFICATION FORM MUST STATE EMERGENCY SERVICE OR INPATIENT ADMISSION

247	NO APPROPRIATE PART A/PART B MEDICARE COVERAGE ON FILE
248	NO APPROPRIATE PART A/PART B MEDICARE COVERAGE ON DATE OF SERVICE
249	NO RATE ON FILE FOR DATES OF SERVICE BILLED
250	RECIPIENT HAS NO MEDICARE CROSSOVER COVERAGE ON FILE
252	PROVIDER NOT AUTHORIZED TO BILL FOR RECIPIENT/X6000
253	RECIPIENT INELIGIBLE FOR SERVICES BILLED
254	AMBULANCE MODIFIER NOT ON FILE
255	VSCRIPT COVERS DRUGS ONLY
257	PROCEDURE/AMBULANCE MODIFIER CODE NOT ON FILE
259	QUANTITY EXCEEDS BENEFIT LIMIT
260	SPECIAL FUNDED RECIPIENT LIMITED TO DRUGS
261	INITIAL DISPENSING LIMITED TO 7 DAY SUPPLY LTC
262	INCREASED DISPENSE FEE DUE TO LTC RESTOCKING
263	FEDERAL STERILIZATION/HYSTERECTOMY CONSENT FORM REQUIRED
264	RESUBMIT ON PAPER/ATTACH EOMB USING RI MA GUIDELINES
265	RESUBMIT ON PAPER WITH EOMB AND MANUFACTURERS INVOICE OR SUGGESTED LIST PRICE
266	CLAIM DENIED FQHC ENCOUNTER CODE MUST BE BILLED ON FIRST DETAIL ONLY
267	SPECIALLY FUNDED RECIPIENT NOT ELIGIBLE FOR MEDICAID
268	PROVIDER TYPE INCONSISTENT WITH BILL TYPE
269	BILL TYPE INCONSISTENT WITH LONG TERM CARE AUTH
270	BILL TYPE INCONSISTENT WITH LTC AUTH > 60 DAYS
271	REVENUE CODE INCONSISTENT WITH PROVIDER TYPE
272	DETAIL DIAGNOSIS POINTERS INVALID (PAPER ONLY)
273	DETAIL DENIAL PAYMENT REDUCTION.
274	CLAIM CHECK SET AT DETAIL
275	AMBULANCE MODIFIER NOT VALID FOR THE DATE OF SERVICE BILLED
280	DETAIL BILLED AMOUNT GREATER THAN $10,000. PLEASE VERIFY AND RESUBMIT
281	DETAIL BILLED AMOUNT IS EXCESSIVE CHARGE. PLEASE VERIFY AND RESUBMIT
283	LAB DETAIL BILLED AMOUNT IS EXCESSIVE CHARGE. PLEASE VERIFY AND RESUBMIT
285	PHARMACY DETAIL BILLED AMOUNT IS EXCESSIVE CHARGE. PLEASE VERIFY AND RESUBMIT
289	MR GROUP THERAPY IS LIMITED TO 40 UNITS (10 HOURS) PER WEEK
290	SURGICAL TRAYS ARE NON-COVERED FOR DATES OF SERVICE PRIOR TO JULY 1, 1987
291	GROUP THERAPY LIMITED TO 2 HOURS (8 UNITS) PER DAY
293	MEDICAID PAID DED/COINS_AMT
294	PLEASE BILL OUTPATIENT SERVICES FOR DIFFERENT CALENDAR YEARS ON SEPARATE CLAIMS
295	PROCEDURE NOT ALLOWED FOR MEDICALLY NEEDY RECIPIENTS
296	HOME HEALTH SERVICES LIMITED TO TWO HOURS PER DAY
297	BILLED DISPENSING FEE NOT EQUAL TO CALCULATED DISPENSING FEE
298	DISPENSING FEE LIMITED TO ONCE PER TWO YEARS
299	MR GROUP THERAPY IS LIMITED TO 8 UNITS (2 HOURS) PER DAY
300	CLAIM DENIED. RESEARCH INDICATES INCORRECT BILLING
301	REBILL CORRECT CODE WITH TOTAL CHARGE
302	CLAIM DENIED. REBILL PAPER CLAIM WITH REQUIRED ATTACHMENTS
303	PLEASE ATTACH MEDICARE EOMB OR RA SHOWING PAYMENT OR DENIAL
304	ORIGINAL MEDICARE EOMB NEEDED TO PROCESS CLAIM
305	CLAIM DENIED. MEDICARE"S ADJUSTMENT EOMB REQUIRED
306	MEDICARE REQUIRES ADDITIONAL INFORMATION. REBILL WITH FINAL DECISION AND EOMB
307	NON-CONSECUTIVE DAYS MUST BE BILLED SEPARATELY
308	THIS MODIFIER IS NOT VALID FOR THE SERVICE BILLED

309	THESE CONSECUTIVE/SIMILAR CODES CANNOT BE BILLED SIMULTANEOUSLY (SAME DOS)
310	THIS MODIFIER IS NOT ACCEPTED BY RHODE ISLAND MEDICAL ASSISTANCE
311	OVERLAPPING ELIGIBILITY. RESUBMIT WITH EOMB AND AN ITEMIZED STATEMENT OF CHARGES
312	DETAIL DENIED. THIS PROCEDURE CODE REQUIRES A MODIFIER
313	THIS PROCEDURE CODE DOES NOT REQUIRE A MODIFIER
315	PLEASE INDICATE START DATE FOR COINSURANCE DAYS
316	BILLED DAYS SUPPLY NOT WITHIN MIN/MAX ALLOWED
317	CLAIM WILL REPROCESS W/ PROC CODE ON 05/30/2006
320	THIS CROSSOVER SERVICE REQUIRES A PAPER CLAIM WITH MEDICARE"S EOMB ATTACHED
321	MEDICARE PAID AMOUNT CANNOT BE DETERMINED. REBILL A PAPER CLAIM WITH EOMB
322	CRNA"S CAN ONLY BE PAID FOR MEDICARE/MEDICAID CROSSOVER CLAIMS
324	SRVCS/QUANTITIES BEING BILLED DO NOT MATCH THE ALLOWED SRVCS/AMOUNTS ON THE PA
325	CLAIM PAYMENT REDUCED BY ASSISTED LIVING PATIENT LIABILITY
326	NAME OF OTHER INSURANCE COMPANY IS NOT PRESENT ON ATTACHMENT
327	THIS CLAIM PAID FOR DEA INCOME LEVEL 1
328	THIS CLAIM PAID FOR DEA INCOME LEVEL 2
329	CLAIM PAYMENT REDUCED BY PATIENT LIABILITY
330	THIS SERVICE COVERED WITHIN THE REIMBURSEMENT FOR THE INITIAL/PRIMARY PROCEDURE
331	DOCUMENTATION REQUIRED SUPPORTING TWO SEPARATE OPERATIVE SESSIONS/SAME DOS
332	PAID AMOUNT REDUCED TO ZERO/PATIENT LIABILITY AMOUNT GREATER THAN ALLOWED AMOUNT
333	SERVICE DENIED AS BEING SAME AS OR INCLUDED IN ANOTHER ON SAME DAY
334	CLAIM PAID ZERO DUE TO PAYMENT POLICY
335	ATTENDING/PERFORMING PHYSICIAN IS NON-PARTICIPATING/NON-REIMBURSEABLE
336	ICN DOES NOT EXIST ON THE MMIS. REPLACEMENT OR VOID DENIED.
338	CLAIM COULD NOT BE REPLACED OR VOIDED. REPLACEMENT OR VOID DENIED.
339	PHARMACY CLAIM DENIED. MANUAL REVIEW REQUIRED. PLEASE REBILL ON PAPER CLAIM
340	PROCEDURE EXCEEDS MAXIMUM UNITS ALLOWED
341	MAXIMUM DRUG QUANTITY LIMIT EXCEEDED
342	SERVICE DENIED MUST SUBMIT TO HEALTH PLAN FOR RITECARE RECIPIENT
343	INDIAN HEALTH ENCOUNTER CODE X0190 MUST BE BILLED ON THE FIRST DETAIL
344	MAXIMUM ALLOWED FOR INDIAN HEALTH CENTER ENCOUNTER CODE
345	NON PDL DRUG REQUIRES AUTHORIZATION
348	RITESHARE EMPLOYER CANNOT RECEIVE CLAIMS PAYMENT
349	YOUR BILLED AMOUNT INDICATES INCORRECT CODE/BILLING
350	CLAIM DENIED. NO PRIOR AUTHORIZATION FOR SUBMITTED SERVICE
352	NON-COVERED GPA SERVICE
353	CLAIM DENIED. NO PARTICIPATION IN ELECTRONIC FUNDS TRANSFER PROGRAM
355	THE NUMBER OF LEAVE DAYS ALLOWED PER CALENDAR YEAR HAVE BEEN EXHAUSTED
356	NDC/AGE MISMATCH
357	PROVIDER NOT AUTHORIZED FOR THESE SERVICES
360	CLAIM DENIED AND RETURNED FOR ADDITIONAL INFORMATION REQUIRED FOR PROCESSING
362	PHYSICIAN SIGNATURE DATE IS ILLEGIBLE. PLEASE CLARIFY
363	HYSTERECTOMY CONSENT FORM REQUIRED
364	PROVIDER SIGNATURE AND DATE ON CONSENT FORM MUST BE ON OR AFTER DATE OF SERVICE
365	HYSTERECTOMY CONSENT FORM MUST BE SIGNED BY RECIPIENT PRIOR TO SURGERY
366	CONSENT FORM IS ILLEGIBLE. PLEASE CORRECT AND RESUBMIT WITH CLAIM
367	EACH PROCEDURE CODE MUST HAVE A CORRESPONDING DATE OF SERVICE (SURGICAL DATE)
368	OPERATIVE NOTES OR EXPLANATION IS ILLEGIBLE. PLEASE RESUBMIT
369	BILATERAL PROCEDURE MUST BE BILLED W/CODE AND THEN SAME CODE WITH SUFFIX -50

370	PATIENT STATUS IS MISSING/INVALID
371	HOLD BED DAYS ARE NOT ALLOWED FOR H3 OR H4 LEVEL OF CARE
372	RECIPIENT PLACEMENT LEVEL IS MISSING/INVALID
373	LEAVE DAYS NOT ALLOWED WHEN RECIPIENT PLACEMENT LEVEL IS H01 OR H02
374	MEDICARE COVERAGE INDICATOR IS MISSING/INVALID
375	HOLD BEDS ARE NOT ALLOWED FOR SWING BED CLAIMS
376	BILLED DAYS ARE EQUAL TO MORE THAN ALLOWED FOR BILLED MONTH
378	NURSING HOME CLAIMS CAN ONLY BE BILLED ONE CLAIM PER MONTH
379	HOLD BED DAYS DENIED. MORE THAN TEN (10) CONSECUTIVE DAYS ARE NOT ALLOWED
380	SIGNATURE REQUIRED FOR CHANGES MADE TO OTHER INSURANCE ATTACHMENT
381	PLEASE PROVIDE DOCUMENTATION OF LETTER/CLAIM SENT TO OTHER INSURANCE COMPANY
382	OTHER INSURANCE ATTACHMENT IS OUTDATED. PLEASE REBILL FOR UP-TO-DATE INFORMATION
383	OTHER INSURANCE ATTACHMENT REQUIRES BREAKDOWN OF PAYMENT APPLIED TO BILLED SERVS
384	CLAIM DENIED. ANOTHER PORTION OF YOUR POLICY TO BE CONSIDERED FOR COVERAGE.
385	EXPLANATION OF OTHER INSURANCE DENIAL IS REQUIRED
386	SECOND DIAGNOSIS IS NOT CONSISTENT WITH THE AGE/SEX OF RECIPIENT
387	ONE OF YOUR SECONDARY DIAGNOSIS CODES IS NOT CONSISTENT WITH SEX OF RECIPIENT
388	AMNIOCENTESIS IS LIMITED TO ONCE PER PREGNANCY
389	WAIVER CASE MANAGEMENT ASSESSMENT CLAIMS MUST HAVE APPROVAL LETTER ATTACHED
390	INSURANCE ATTACHMENT REQUIRES INFORMATION. REBILL WITH DENIAL OR PYMT DECISION
391	DATES ON INSURANCE ATTACHMENT DO NOT MATCH THE SERVICE DATES ON THE CLAIM
392	THIS IS A NON-COVERED SERVICE WHEN RULES DO NOT COMPLY WITH HMO
393	PLEASE ATTACH A COPY OF YOUR MEDICARE DETERMINATION FORM
394	PLEASE RESUBMIT WITH ORIGINAL OTHER INSURANCE ATTACHMENT
395	CLARIFICATION NEEDED AS TO WHICH PROCEDURE (OR PART OF TOTAL) 99 CODE REPRESENTS
396	NO MEDICAID BENEFITS DUE-MEDICAID POLICY IS SAME AS MEDICARE FOR THIS SERVICE
397	MEDICARE DENIAL SHEET IS INCOMPLETE/INVALID
398	INSURANCE ATTACHMENTS SHOW A MAJOR MEDICAL PENDING. CLAIM DENIED
399	PLEASE RESUBMIT W/INVOICE SHOWING WHAT YOU PAID FOR SERUM OR OTHER EXPLANATION
400	PLEASE BILL MEDICARE FIRST AND ATTACH COPY OF PAYMENT OR DENIAL
401	YOUR CLAIM HAS BEEN REFERRED TO DHS FOR FILE REVIEW.
402	INSURANCE BENEFIT SHEET DOES NOT MATCH CLAIM
403	NO CROSSOVER PAYMENT DUE. PROVIDER DID NOT ACCEPT ASSIGNMENT
404	PLEASE INDICATE THE AMOUNT PAID BY OTHER INSURANCE ON THE CLAIM FORM
405	CLAIM/DETAIL DENIED. NOT FILED WITHIN THE TIME FRAME ALLOWED
406	RESUBMIT 11 MONTHS FROM DOS WITH PROOF OF SUBMITTAL/REPLY FROM OTHER INSURANCE
407	YOUR CLAIM HAS BEEN REFERRED TO DHS FOR FILE REVIEW. WE WILL RESUBMIT THE CLAIM
408	PLEASE BILL OTHER INSURANCE CARRIER FIRST AND ATTACH COPY OF PAYMENT OR DENIAL
409	PLEASE PROVIDE DATES OF SERVICE ON INSURANCE ATTACHMENT
410	ORTHODONTIC TREATMENT MUST BE BILLED IN SIX MONTH TIME PERIODS
411	RECIPIENT INELIGIBLE FOR A PORTION OF THE DAYS BILLED
412	PATIENT UNAUTHORIZED FOR A PORTION OF DAYS BILLED-CHECK AUTHORIZATION & REBILL
413	RECIPIENT HAS OTHER INSURANCE TO BE CONSIDERED
414	PLEASE RESUBMIT AND INDICATE THE NUMBER OF TESTS PERFORMED
415	TREATMENT OF ACCIDENTAL INJURY MUST BE PROVIDED WITHIN 72 HOURS OF THE ACCIDENT
416	DIAGNOSIS/SITUATION DOES NOT WARRANT EMERGENCY ROOM SERVICE
417	THIS "LOCK-IN" RECIPIENT CAN ONLY BE TREATED BY A SPECIFIC PROVIDER
418	CLAIM IS PAST THE 365 DAY BILLING LIMITATION TIME FRAME
419	CLAIM/DETAIL DENIED. RECHECKS ARE NOT A LEGITIMATE EMERGENCY

420	CLAIM DENIED. TRUE EMERGENCY REQUIRES PRESENCE OF/EXAM BY A PHYSICIAN
421	BILLING OF REVENUE CODE 450 (ER) REQUIRES RECORD SHOWING TIME AND MD SIGNATURE
422	PLEASE RESUBMIT WITH THE SUPPLIER/MANUFACTURER INVOICE ATTACHED
423	RECIPIENT NOT ELIGIBLE FOR DEA WAIVER ON DOS
424	PLEASE CONTACT DHS FOR CONSIDERATION OF LATE CHARGES
425	PLEASE SUBMIT CLAIM AND ATTACHMENTS TO DHS FOR REQUIRED PRIOR AUTHORIZATION
426	PRIOR AUTHORIZATION NUMBER/ATTACHMENT IS MISSING/INVALID
427	MEDICAL NECESSITY AND PRIOR AUTHORIZATION REQUIRED
428	CLAIM DENIED. REQUIRED ATTACHMENT MUST HAVE AUTHORIZED SIGNATURE
429	RI MEDICAID REIMBURSEMENT FOR MULTIPLE SURGERY APPLIES ONLY TO TWO PROCEDURES
430	PROC CODES ENDING IN 99 REQUIRE DOCUMENTATION. RESUBMIT W/NOTES OR EXPLANATION
431	INFORMATION ON MEDICAL NECESSITY FORM DOES NOT MATCH CLAIM
432	PLEASE RESUBMIT WITH A MEDICAL NECESSITY FORM
433	CLAIM REQUIRES MANUAL PRICING. PLEASE RESUBMIT ON PAPER WITH ATTACHMENTS
434	CLAIM DENIED. THE REQUESTED DOCUMENTATION WAS NOT RECEIVED
435	REFER TO MANUAL FOR SPECIAL MEDICAID INJECTION CODES ("J" CODES)
436	CLAIM REQUIRES MANUAL PRICING. INADEQUATE OR INSUFFICIENT INFORMATION PROVIDED
437	INAPPROPRIATE PROCEDURE CODE. PLEASE REFER TO YOUR LIST OF ALLOWED CODES
438	CLAIM DENIED. THIS PROCEDURE REQUIRES MEDICAID AUTHORIZATION PRIOR TO SERVICE
439	PRIMARY SURGERY IS MANUALLY PRICED AT 100% OF ALLOWED AMOUNT
440	SECONDARY SURGERY IS MANUALLY PRICED AT 50% OF ALLOWED AMOUNT
441	ASSISTANT SURGEON IS NOT ALLOWED WITH THIS PROCEDURE CODE
442	REHABILITATIVE THERAPY START DATE IS MISSING/INVALID
443	CLAIM DENIED. DATE OF MEDICARE BENEFIT SHEET IS OVER SIX MONTHS
444	CLAIM/DETAIL DENIED. PLEASE RESUBMIT WITH LEGIBLE EMERGENCY ROOM RECORDS
445	NOTES/CONSENT FORM INCOMPLETE AND/OR ILLEGIBLE
446	PA REQUIRED FOR REHAB THERAPY IF GREATER THAN 4 MONTHS FROM START DATE
447	NOTES/CONSENT FORM INVALID
448	ATTENDING/PERFORMING PROVIDER NUMBER MUST BE FOR AN INDIVIDUAL PROVIDER
449	REHABILITATIVE/HOSPICE SERVICES SHOULD BE BILLED AS 1 UNIT PER DATE OF SERVICE
450	CANNOT BILL THIS CODE DUE TO LACK OF AUTHORIZATION FOR THE LAB SPECIALTY
451	COMPOUND DRUG REQUIRES INDIVIDUAL INGREDIENTS
452	THE QUANTITY OF INGREDIENTS USED IN THE COMPOUND DRUG MUST BE LISTED
453	NOT BILLED ACCORDING TO COMPOUND PRICING FORMULA
454	REVENUE CODE 760 REQUIRES ADMISSION HX/ER RECORD AND PROGRESS NOTES
455	THIS PROCEDURE MAY ONLY BE BILLED AS ONE UNIT OF SERVICE
456	DHS REQUIRES THIS SERVICE BE PROVIDED IN SESSIONS OF AT LEAST 1/2 HOUR (2 UNITS)
457	NDC REQUIRES THE PREGNANCY INDICATOR SHOULD BE EQUAL TO ONE
458	CLAIM IS PRICED AT THE RHODE ISLAND MULTI-SOURCE DRUG PRICE
459	TAPE BILLING PROVIDER IS NOT ELIGIBLE TO BE BILLED FROM THIS SUBMITTOR.
460	NON-COVERED SERVICE - RECIPIENT IS AGE 21 OR OLDER
461	LAB INDICATOR MISSING/INVALID OR INDICATES LAB PROC MUST BE PROCESSED ON-SITE
462	CLAIM BILLED AMOUNT EXCEEDS MAXIMUM DOLLARS ALLOWED
463	TREATMENT AND PLAN OF CARE MUST BE DOCUMENTED
465	DIAGNOSIS/PROCEDURE IS NOT CONSISTENT WITH THE RECIPIENT"S SEX
466	DIAGNOSIS/PROCEDURE IS NOT CONSISTENT WITH THE RECIPIENT"S AGE.
467	NOTES INDICATE NEW OBSERVATION SERVICE REVENUE CODE NEEDED
468	THIS PROCEDURE CODE IS FOR THE MOTHER"S SIX-WEEK POSTPARTUM CHECKUP.
469	ELIGIBLE ONLY FOR STATE FUNDED DAY SERVICES, ON DATE OF SERVICE

470	99 CODE NOT PERMITTED UNLESS PRIMARY SURGEON USED OR WAS PAID FOR SAME PROC CODE
471	STATE FUNDED RECIPIENT HAS NO REHAB PERCENTAGE ON FILE
472	ASSIST. SURGEON CANNOT BE PAID UNTIL PRIMARY SURGEON HAS BEEN PAID FOR THIS CODE
473	RECIPIENT HAS NO REHAB PERCENTAGE ON FILE
474	PLEASE RESUBMIT WITH COMPLETE HOSPITAL RECORD
475	DATE OF DELIVERY MUST BE ON CLAIM WHEN BILLING D&C FOR POST PARTUM HEMORRHAGE
476	CLAIM MODIFIER DOES NOT MATCH REHAB LEVEL FOR STATE FUNDED RECIPIENT
477	CLAIM MODIFIER DOES NOT MATCH RECIPIENT REHAB LEVEL
478	ASSISTANT SURGEON MUST USE THE SAME PROCEDURE CODE USED BY THE PRIMARY SURGEON
479	PSYCHIATRIC/EMOTIONAL DISORDERS/SUBSTANCE ABUSE REQUIRE PRO PRIOR AUTHORIZATION
480	EXPLANATION REQUIRED RE. MEDICAL NEED FOR GENERAL ANESTHESIA WITH THIS PROCEDURE
481	D&C FOR POSTPARTUM HEMORRHAGE NOT COVERED IF PERFORMED WITHIN 7 DAYS OF DELIVERY
482	CLAIM DENIED. PLEASE RESUBMIT WITH AUTHORIZED DENTAL FORM
483	PRIOR AUTH REQUIRED FROM DHS FOR DENTAL CODES IF RECIPIENT IS 21 AND OLDER
484	THESE SERVICES ARE COVERED IN FEE PAID FOR TOTAL OB CARE
485	NDC NOT VALID FOR DATE OF SERVICE. MANUFACTURER"S CHANGE
486	THE ONLY MEDICAID-COVERED CHIROPRACTIC SERVICE IS SPINAL MANIPULATION
487	CODE NEEDS OP NOTES AND EXPLANATION TO JUSTIFY INDIVIDUAL CONSIDERATION.
488	NITROUS OXIDE NOT COVERED FOR PROVIDER/PATIENT CONVENIENCE.
489	CHIROPRACTORS ARE ALLOWED TO BILL ONLY DIAGNOSIS CODES 83900 THROUGH 83959.
490	NDC HAS NO PRICE ON FILE FOR DISPENSE DATE
491	INDIVIDUAL"S EXPECTED DATE OF DELIVERY (SEE CONSENT FORM) NEEDED FOR PROCEDURE
492	EPSDT INDICATOR MUST BE YES IF EPSDT PROCEDURE CODES ARE BILLED.
493	MULTIPLE ERRORS ON CONSENT FORM. PLEASE CONTACT COMMUNICATIONS FOR ASSISTANCE
494	EACH E.R. VISIT MUST BE BILLED SEPARATELY. DO NOT COMBINE INTO ONE CLAIM/BILL
495	RECIPIENT SIGNATURE ON CONSENT FORM MUST BE ON OR BEFORE THE DATE OF SERVICE
496	THE DATES OF SERVICE ON THE CLAIM DISAGREE WITH THOSE ON THE CONSENT FORM
497	THE RECIPIENT MUST BE 21 TO LEGALLY SIGN THE FEDERAL STERILIZATION CONSENT FORM
498	DATE OR DATES ON THE CONSENT FORM ARE ILLEGIBLE. PLEASE CLARIFY AND RESUBMIT
499	STERILIZATION CAN BE PAID ON THE 31ST DAY-30 DAYS MUST PASS AFTER PATIENT SIGNS
500	STERILIZATION MUST BE 180 DAYS OR LESS FROM DATE THE CONSENT SIGNED BY RECIPIENT
501	PROCEDURE ON CONSENT FORM MUST AGREE WITH THAT ON THE CLAIM
502	THE CONSENT FORM IS INCOMPLETE
503	TIME LIMIT DENIED BY DHS. RESUBMIT ONLY IF NEW DOCUMENTATION IS AVAILABLE
504	DETAIL DENIED. PLEASE RESUBMIT WITH OP NOTES/EXPLANATION OF PROCEDURE
505	DATA SUBMITTED DOES NOT SUBSTANTIATE PROCEDURE BILLED.
506	OUR FILE INDICATES NO AUTHORIZATION FOR DATE OF SERVICE.
507	APPLIED INCOME NOT CURRENT ON ELIG FILE. CONTACT DISTRICT OFFICE FOR CORRECTION
508	RESUBMIT WITH OPERATIVE/PROCEDURE NOTES, MEDICAL HISTORY AND DISCHARGE SUMMARY
509	CLAIM DENIED. LEAVE DAYS NOT COVERED
510	CLAIM DENIED. MAXIMUM NUMBER OF LEAVE DAYS HAS BEEN EXCEEDED
511	PLEASE RESUBMIT WITH AN EXPLANATION WHY SERVICE WAS MEDICALLY NECESSARY
512	RECIPIENT NOT AUTHORIZED FOR THIS LEVEL OF CARE
513	CLAIM DENIED. INDEPENDENT LAB HAS ALREADY BEEN PAID FOR THIS SERVICE
514	DENIED. SUBMITTED DATA DOES NOT JUSTIFY MEDICAL NECESSITY FOR ITEM(S) PROVIDED
515	DENIED. STERILIZATION CONSENT MUST BE GIVEN AT LEAST 72 HOURS PRIOR TO PROCEDURE
516	PLEASE SUBMIT WITH ADMISSION HISTORY AND DISCHARGE SUMMARY.
517	PLEASE SUBMIT WITH DATA AND AN EXPLANATION SUBSTANTIATING PROCEDURE/TIME/UNITS
518	THIS ITEM IS LIMITED TO ONE UNIT PER YEAR (365 DAYS) PER RECIPIENT

519	PLEASE RESUBMIT EXPLAINING HOW MUCH TIME WAS SPENT FOR THE BILLED PROCEDURE
520	PLEASE RESUBMIT EXPLAINING WHY A D&C WAS MEDICALLY NECESSARY.
521	DATA SUBMITTED DOES NOT SUBSTANTIATE A MEDICAL NECESSITY
522	A D&C NOT MEDICALLY NECESSARY. PLEASE REBILL AND OMIT D&C RELATED SERVICES
523	HOSPITAL CLAIM MUST BE PAID PRIOR TO PRIMARY SURGEON
524	PRIMARY SURGEON MUST BE PAID PRIOR TO ASSISTANT SURGEON OR ANESTHESIOLOGIST
525	BENEFITS FOR REMOVAL/REPAIR OF ORGANS INJURED DURING SURGERY ARE NOT PROVIDED
526	PLEASE RESUBMIT WITH LAB AND/OR X-RAY RESULTS
527	ALL ITEMS BILLED MUST BE DOCUMENTED AND JUSTIFIED ON THE MEDICAL NECESSITY FORM
528	JUSTIFICATION IS REQUIRED FOR MEDICAL NECESSITY FOR THIS LENGTH OF STAY
529	RELEVANT HISTORY REQUIRED FOR PROCESSING (HOSPITAL-OFFICE RECORDS SHOWING HX)
530	PAID HOME VISITS ARE LIMITED TO 24 PER YEAR/2 PER MONTH
531	CLAIMS FOR GRAFT CODES MUST INCLUDE DOCUMENTATION OF THE AREA COVERED
532	OUR FILES INDICATE AUTHORIZATION FOR DIFFERENT PROVIDER FOR ALL OR PART OF DOS
533	CLAIM SUSPENDED DUE TO DHS REVIEW OF RATES.
534	PRIOR AUTHORIZATION EXHAUSTED FOR SERVICE BILLED
535	INPATIENT ADMISSIONS LIMITED TO $75,000 FOR DATES OF SERVICE AFTER 7/1/96
536	HOLD BEDS NOT ALLOWED WHEN ORIGINAL ADMISSION DATE IS AFTER 7/01/90
538	NORPLANT CONTRACEPTIVE SYSTEM COVERED ONCE EVERY 5 YEARS PER RECIPIENT.
539	APPLIANCE THERAPY IS LIMITED TO ONCE PER 730 DAYS
540	ONLY ONE NICU REVENUE CODE PER CLAIM
541	IN ADDITION TO PER DIEM RATE DETAIL, MUST BILL INFORMATIONAL DETAILS
542	ONLY AUTHORIZED NICU PROVIDERS MAY BILL REVENUE CODES 203 AND 209
543	BILLING PROVIDER NOT AUTHORIZED TO BILL THIS PROCEDURE CODE
544	MHRH RECIPIENT MUST HAVE A FULL MONTH SEGMENT
545	RECIPIENT HAS NO REHAB PERCENTAGE ON FILE/X6000
546	STATE FUNDED RECIPIENT HAS NO REHAB PERCENTAGE ON FILE/X6000
547	CLAIM MODIFIER DOES NOT MATCH RECIPIENT REHAB LEVEL/X6000
548	CLAIM MODIFIER DOES NOT MATCH REHAB LEVEL FOR STATE FUNDED RECIPIENT/X6000
549	PARTIAL MONTH BILLING REQUIRES PROC CODE X6010
550	RECIPIENT REHAB PERCENTAGE NOT ON FILE
551	DISPENSING FEE CUT BACK DUE TO NH DISPENSE FEE POLICY
552	THIS SERVICE REQUIRES SPLIT BILLING FOR MANAGED CARE RECIPIENTS
553	NUMBER OF UNITS BILLED EXCEEDS NUMBER OF UNIT AUTHORIZED
554	THIS SERVICE IS NOT COVERED FOR RITE START RECIPIENTS
555	THIS SERVICE IS NOT COVERED FOR MANAGED CARE RECIPIENTS
556	PAYMENT FOR SERVICE INCLUDED IN PER DIEM RATE
557	THIS SERVICE IS NOT COVERED FOR MANAGED CARE RECIPIENTS
559	EFP RECIPIENT NOT ELIGIBLE FOR SERVICE
560	SEPERATE COMPONENTS HAVE BEEN INCLUDED IN COMPREHENSIVE PANEL
561	RECIPIENT NOT MANAGED CARE ELIGIBLE FOR BILLING PROVIDER - SOBRA
562	BILLING PROVIDER NOT RECIPIENT"S PROVIDER AT TIME OF PREGNANCY OUTCOME - SOBRA
563	TYPE OF PREGNANCY OUTCOME INVALID/MUST BE 1, 2, OR 3 - SOBRA
564	FIRST TYPE OF DELIVERY INVALID - SOBRA
565	SERVICE DENIED AS CONSIDERED COSMETIC
566	THIRD PREGNANCY OUTCOME OR TYPE OF DELIVERY INVALID - SOBRA
567	PREGNANCY OUTCOME LESS THAN 20 WEEKS/INDUCED ABORTION NOT ELIGIBLE - SOBRA
568	GESTATION AGE MISSING/INVALID - SOBRA
569	DELAYED CLAIM/CAPITATION ADJUSTMENT - SOBRA

570	OUR HISTORY FILES SHOW NO BILLING FOR THE MOTHER"S DELIVERY
571	SOBRA CLAIM LIMITED ONCE PER 140 DAYS
572	COMPND SEG MUST BE PRESENT WHEN COMPND IND=2
573	CLIA DATES DO NOT INCLUDE DATE OF SERVICE
575	MAXIMUM DOSE ALERT
576	MINIMUM DOSE ALERT
577	LATE REFILL
578	INPATIENT CLAIMS OF ONE DAY IN LENGTH REQUIRE DISCHARGE HOUR
579	PHARMACY CLAIM DATE OF SERVICE GREATER THAN 7/1/94
580	MAINTENANCE ON OXYGEN CONCENTRATORS LIMITED TO ONCE EVERY TWO MONTHS
581	INVALID PLACE OF SERVICE FOR FQHC OPTOMETRY/PODIATRY PROCEDURE
582	INVALID PLACE OF SERVICE FOR FQHC IN-HOSPITAL PROCEDURE
583	RECIPIENT WAS DECEASED ON CLAIM DATE OF SERVICE
584	RECIPIENT MUST HAVE ENROLLMENT IN MANAGED CARE PLAN
585	THIS SERVICE IS NOT COVERED FOR RECIPIENT
590	THE MAXIMUM DOLLAR AMOUNT ALLOWED PER DAY HAS BEEN MET
591	TERMINATED NDC, TRY ALTERNATIVE
592	DESI DRUG, NDC NOT COVERED
593	NDC NOT COVERED, DRUG CLASS NOT COVERED
594	NON-REBATEABLE NDC, TRY ALTERNATIVE
595	NDC REMOVED FROM MARKET, TRY ALTERNATIVE
596	DO NOT PAY, NO PRICE ON FILE
598	DME RENTAL LIMIT HAS BEEN EXCEEDED
599	RECIPIENT NAME IS MISSPELLED.
600	DOCUMENT DRUG"S NAME,STRENGTH,EXACT QUANTITY USED AND HOW ADMINISTERED IS REQD
601	DIAGNOSIS CODE CANNOT BE MATCHED WITH NASALECTOMY PROCEDURE
604	MORE THAN ONE PROCEDURE PER DAY WITH THE SAME DIAGNOSIS REQUIRES A P.A.
606	CLAIM UNITS BILLED EXCEEDS REMAINING AUTHORIZED UNITS ON PA
607	AGE CONFLICT ALERT
608	OBSTETRICAL DELIVERY PAYMENTS ARE LIMITED TO ONCE PER 280 DAYS.
609	THIS OPTOMETRY SERVICE IS NON-COVERED PRIOR TO DATE OF SERVICE 07/01/89.
610	PSYCHOTHERAPY UNITS GREATER THAN ONE
611	PRESCRIPTION/FIT OF CONTACT LENS CANNOT BE PAID UNTIL LENS ITSELF PAID/APPROVED
612	DISPENSING FRAMES OR PRESCRIBING CONTACT LENSES LIMITED TO ONE PER 730 DAYS
613	DISPENSING OF LENSES LIMITED TO TWO PER 730 DAYS
614	OFFICE/MEDICAL VISITS CANNOT BE PAID WITH THE SAME DATE OF SERVICE AS SURGERY
615	RECIPIENT NOT ELIGIBLE FOR SERVICES
616	QMB RECIPIENT NOT ELIGIBLE FOR SERVICES
619	CLAIM DENIED FOR EARLY REFILL
620	CLAIM DENIED SAME THERAPEUTIC CLASS CODE
621	CLAIM DENIED; NO CORRESPONDING CLAIM ON FILE
622	THIS IS A NON-COVERED SERVICE FOR THIS PROVIDER
623	COMPOUND DRUG - SUBMIT WITH INGREDIENT NDC"S
624	NDC NOT COVERED
625	MUST BE PARTICIPATING PROVIDER W/PRIMARY INSURER
626	NO LONG TERM CARE AUTH. ON FILE FOR DATES OF SERVICE BILLED/CLAIM > 60 DAYS OLD
627	RPL ON CLAIM DOESN"T MATCH RPL ON LONG TERM CARE AUTH. FILE/CLAIM > 60 DAYS OLD
628	PROV. ON CLAIM DOESN"T MATCH PROV. ON LONG TERM CARE AUTH. FILE/CLAIM > 60 DAYS
629	GAP IN BILLED DAYS/SPLIT MONTH CLAIM. CLAIM GREATER THAN 60 DAYS OLD.

630	BILL PROVIDER CANNOT DISPENSE ORAL CONTRACEPTIVES
631	NO LONG TERM CARE AUTHORIZATION ON FILE FOR DATES OF SERVICE BILLED
632	LTC PATIENT LIABILITY AMOUNT DOES NOT MATCH LIABILITY AMOUNT ON CLAIM SUBMITTED
633	GAP IN BILLED DAYS/SPLIT MONTH CLAIM
634	YOUR PROVIDER TYPE CANNOT BILL THE RPL SUBMITTED ON CLAIM
635	PROVIDER ON CLAIM SUBMITTED DOES NOT MATCH PROVIDER ON LONG TERM CARE AUTH FILE
636	REVENUE CODE 636 COVERS ONLY INJECTED CHEMOTX AGENTS.HCPCS OR NDC IS REQUIRED.
637	RPL ON CLAIM SUBMITTED DOES NOT MATCH RPL ON LONG TERM CARE AUTHORIZATION FILE
638	THE MAXIMUM ALLOWED ($176 PER 30 DAYS) FOR INFUSION PUMP RENTAL HAS BEEN REACHED
639	OPTOMETRY BILLING PROVIDER CANNOT BILL LEVEL 1 MODIFIER
645	CLAIM DENIED FOR DRUG TO DRUG INTERACTION
646	CLAIM DENIED FOR DRUG GENDER
651	DRUG QUANTITY AND/OR DAYS SUPPLY LESS THAN MINIMUM QUANTITY
655	DETAIL PROCEDURE CODE NOT VALID
656	DETAIL MODIFIER NOT VALID
657	DETAIL PROCEDURE CODE NOT VALID FOR DATE OF SERVICE
658	DETAIL MODIFIER ON REVIEW
659	MODIFIER NOT VALID FOR DATE OF SERVICE
660	MODIFIER BILLED IS NOT COVERED BY RI MEDICAL ASSISTANCE
666	BILLED QUANTITY NOT WITHIN DRUG RX MINIMUM/MAXIMUM VALUES
668	PAYABLE THROUGH DME PROGRAM
670	OTHER INSURANCE CARRIER CODE IS MISSING/INVALID
674	OTHER INSURANCE PAYMENT AMOUNT IS MISSING/INVALID
675	RECIPIENT HAS NO WAIVER ELIGIBILITY
676	RECIPIENT WAIVER SEGMENT INCONSISTENT WITH PROCEDURE BILLED
677	RECIPIENT NOT ELIGIBLE FOR DEA SERVICES BILLED
678	RECIPIENT NOT ELIGIBLE FOR MR/DD WAIVER ON DOS
679	THE MAXIMUM OF $200 PER DAY PER CLIENT FOR MR SERVICES HAS BEEN MET
680	RECIPIENT NOT ELIGIBLE FOR PARI WAIVER ON DOS
681	MULT WISDOM TOOTH EXTRACTIONS ON ADULTS REQUIRES PRIOR AUTHORIZATION FROM DHS
682	RECIPIENT NOT ELIGIBLE FOR SDC WIAVER ON DOS
683	RECIPIENT NOT ELIGIBLE FOR A&D WAIVER ON DOS
684	CLAIM BILLED WITHOUT HEADER CLAIM ADJUSTMENT SEGMENT
685	DAY HOSPITAL CANNOT BE BILLED WITH CHEMO, GROUP, PSYCHOTHERAPY OR DAY RX
686	ADJ RSN FOR RITESHARE RECIP BILLED MORE THAN ONCE FOR PR CODE/HEADER
687	ADJ RSN FOR RITESHARE RECIP BILLED MORE THAN ONCE FOR PR CODE/DETAIL
688	CLAIM ALLOWABLE GREATER THAN BILLED DUE TO COPAY
689	CLAIM PAYMENT INCLUDED IN COPAY PAYMENT
690	FEDERALLY QUALIFIED HEALTH CENTER VISITS LIMITED TO ONE PER DAY
691	BILL CO-PAY AMOUNT FOR RITESHARE RECIPIENT
692	PAYMENT REQUIRED FROM RECIPIENT
693	CO-PAY BILLED AMOUNT MEETS OR EXCEEDS MAXIMUM ALLOWED
694	ANESTHETIC MANAGEMENT LIMITED TO ONE METHOD PER PATIENT FOR SAME DAY OF SERVICE
695	OTHER INSURANCE DID NOT PAY. PLEASE SUBMIT ON PAPER FOR REVIEW
696	PAYMENT MUST BE COLLECTED FROM OTHER INSURANCE CARRIER
697	OTHER COVERAGE CODE INCONSISTENT WITH OTHER PAYER AMOUNT
698	INVALID OTHER COVERAGE CODE
699	HOSPITALIZATION STAMP FROM DHS IS REQUIRED WITH INPATIENT DENTAL SERVICES
700	RI MEDICAID DOES NOT REIMBURSE FOR CARE OF CORNS AND CALLUSES

701	CLAIM/DETAIL DENIED. PLEASE RESUBMIT WITH ANESTHESIA RECORD.
702	THIS SERVICE NOT COVERED FOR PERSONS OVER 21 UNLESS FOR PRESURGICAL DIAGNOSIS
703	PLACE OF SERVICE CODE MISSING/INVALID.
704	PROCEDURE CODE NOT CONSISTENT WITH PROVIDER TYPE.
705	PROCEDURE NOT CONSISTENT WITH PROVIDER SPECIALTY.
706	PROCEDURE CODE NOT CONSISTENT WITH DIAGNOSIS.
707	PLEASE RESUBMIT WITH A MORE SPECIFIC DIAGNOSIS
708	E CODES MAY NOT BE BILLED AS A PRIMARY DIAGNOSIS
709	ADULT DENTAL SERVICES ARE NOT COVERED BY RI MEDICAID PRIOR TO JANUARY 1, 1989
710	PLEASE USE APPROPRIATE PROVIDER NUMBER ASSIGNED FOR THIS SERVICE
711	CHIROPRACTIC VISITS FOR RECIPIENTS LESS THAN 12 YEARS OLD REQUIRES PA
712	BENEFIT LIMIT HAS BEEN EXHAUSTED
713	CLAIM PAID ZERO. RECIPIENT CO-PAY IS 100%
714	RECIPIENT MAX OUT OF POCKET HAS BEEN MET
716	HOSPICE AND HOMEHEALTH PROV TYPE NOT CONSISTENT WITH PROCEDURE CODE/PROV TYPE
717	OVERRIDE NOT ALLOWED
718	DISPENSE BRAND NAME
719	OTHER INSURANCE PAID GREATER THAN ZERO, NO RIPAE PAYMENT
720	RECIPIENT NOT ELIGIBLE FOR ASSISTED LIVING WAIVER SERVICE
721	PROVIDER NOT AUTHORIZED TO BILL NON-MA EI RECIPIENTS
722	MEDICARE D APPEAL REQUIRED PRIOR TO RIPAE COVERAGE
723	SYSTEM TIMEOUT EDIT
724	INVALID POS SUBMITTER IDENTIFICATION
725	DUPLICATE PAID PRESCRIPTION
726	THIS NDC IS NOT ALLOWED FOR POS DEVICE-PLEASE SUBMIT PAPER CLAIM
727	TTL UNITS/DAYS BILLED DOES NOT MATCH ORIG RX QTY
728	PARTIAL FILL INFORMATION MISSING OR INVALID
729	MATCHING PARTIALLY FILLED CLAIM NOT FOUND
730	PSYCHIATRIC DIAGNOSIS AND EVALUATION INTERVIEWS LIMITED TO 5 HOURS PER YEAR
731	GROUP PSYCHOTHERAPY LIMITED TO 24 UNITS/WK OR 6 HOURS/WK
732	LEA SERVICES FOR RECIPIENT WITH AID CATEGORY OF J1 THRU J8
733	FAMILY CARE PLAN REV OR FAMILY CARE PLAN DEVELOPMENT MUST BE PAID
734	MUST BILL IFA BEFORE BILLING PROC CODE FOR FAMILY CARE PLAN
735	CEDARR CASE RATE MAXIMUM $50.00 PER CALENDAR MONTH
736	PROC CODE REQUIRES CEDARR REGISTRATION ON FILE RECIP/CFC ON DOS
737	REFERRING PROVIDER MUST BE CFC FOR RECIPIENT ON DOS
738	COST OF ADMINISTERING MEDICATION ALREADY INCLUDED IN PRIMARY CODE
739	EOB FOR CHECKING DUPLICATE CLAIM AUDITS
740	W PROCEDURE CODES ON DENTAL CLAIMS ARE INVALID AFTER 7/15/88.
741	ALL COMPLEX THIRD MOLAR SURGERY LIMITED TO SINGLE SYMPTOMATIC TEETH
742	INVALID INTENDED DAYS AND OR QTY
744	PAYMENT CUT BACK TO MAXIMUM DOS LIMIT FOR INTRAORAL FILMS
745	CHIROPRACTIC VISITS LIMITED TO 10 PER CALENDAR YEAR
748	CLAIM DENIED. INCORRECT BILLING OF RECIPIENT NAME FOR THIS CLAIM TYPE.
749	SERVICE DENIED BY DHS/DENTAL
751	SEALANTS LIMITED TO OCCLUSAL SURFACE/TEETH
752	PERMANENT CROWNS LIMITED TO 1 PER TOOTH EVERY 2 YEARS
753	PULPOTOMY LIMITED TO ONCE PER DECIDUOUS TOOTH PER LIFETIME
754	ROOT CANAL THERAPY LIMITED TO ONE PROCEDURE PER TOOTH PER RECIPIENT LIFETIME

756	ENDODONIC IMPLANTS LIMITED TO 1 PER TOOTH PER 2 YEARS
760	PERIODONTAL SCALING PER QUADRANT LIMITED TO ONCE PER 365 DAYS, ANY PROVIDER
761	PARTIAL AND COMPLETE DENTURES LIMITED TO ONE PER FIVE YEARS, ANY PROVIDER
762	PROCEDURE LIMITED TO 1 PER 180 DAYS
763	PROCEDURE LIMITED TO 1 PER 365 DAYS
764	EXTRACTIONS LIMITED TO ONCE PER TOOTH PER LIFETIME
765	BITEWINGS ARE LIMITED TO 4 UNITS PER DATE OF SERVICE PER DHS
766	PARTIAL RADIOGRAPHS CANNOT BE BILLED ON THE SAME DOS AS A COMPLETE SERIES
767	PROCEDURE LIMITED TO 4 UNITS PER LIFETIME
768	PROCEDURE LIMITED TO ONE UNIT PER 180 DAYS FOR ANY PROVIDER
769	MENTAL RETARDATION SERVICES ARE LIMITED TO $200 PER DAY PER CLIENT
771	PREFABRICATED CROWNS LIMITED TO 1 PER ANTERIOR TOOTH PER LIFETIME, ANY PROVIDER
773	PREOP SERVICE NOT ALLOWED WITHIN ONE DAY OF SURGERY
774	DENTAL PROCEDURES D5212 AND D5214 CANNOT BE BILLED TOGETHER ON THE SAME DATE
776	POSTOP/PREOP SERVICE NOT ALLOWED WITHIN 30 DAYS OF SURGERY
777	CANNOT BILL LAB PANEL & SEPARATE COMPONENTS SAME DOS
778	DENTAL PROCEDURES D5730 AND D5750 CANNOT BE BILLED TOGETHER ON THE SAME DATE
780	DENTAL PROCEDURES D5740 AND D5760 CANNOT BE BILLED TOGETHER ON THE SAME DATE
783	ENTERAL SUPPLIES ARE LIMITED TO A MAXIMUM OF $220 PER 30 DAYS
789	CLIENT CANNOT RECEIVE BOTH OUTPATIENT AND RESIDENTIAL TREATMENT ON THE SAME DOS
790	THIS SERVICE/ITEM LIMITED TO ONCE PER RECIPIENT LIFETIME
793	SAME X-RAY/INTERPRETATION ON SAME DAY REQUIRE DOCUMENTATION OF NECESSITY
794	PAYMENT ADJUSTMENT DUE TO PROVIDER ACCOMMODATION RATE REDUCTION
795	CLAIM DENIED OUTPATIENT SURGERY ALREADY PAID ON SEPERATE CLAIM FOR SAME DOS
796	PAID AMOUNT IS ZERO. THREE OUTPATIENT SURGERIES PAID.
797	DETAIL DENIED AS INCLUDED IN MEDICAID REIMBURSEMENT FOR NURSING HOME STAY
799	DETAIL DENIED AS INCLUDED WITHIN OR IDENTICAL TO A CONCURRENTLY BILLED SERVICE
800	MORE THAN ONE PGC 2, SAME DOS, REQUIRES ADMISSION HISTORY & PROCEDURE/OP NOTES
801	DETAIL DENIED. ANOTHER PROVIDER HAS ALREADY BEEN PAID FOR THE SAME SERVICE
802	A MAXIMUM OF FIVE HOME VISITS PER MONTH ARE ALLOWED BY THE SAME PROVIDER
803	ONLY 5 LIKE PROCEDURES PER 30 DAYS ARE PERMITTED FOR THE SAME PROVIDER
804	ONLY ONE PROCEDURE PER DAY IS ALLOWED FOR THE SAME DIAGNOSIS
805	NURSING HOME VISITS ARE LIMITED TO FIVE PER MONTH
806	VITAMIN B12 INJECTIONS ARE LIMITED TO ONE PER MONTH
807	LUMBAR-SACRAL ORTHOSES LIMITED TO 2 PER 365 DAYS
808	OUR HISTORY FILE INDICATES THIS IS NOT THE INITIAL VISIT FOR PLANNED PARENTHOOD
809	PLANNED PARENTHOOD ANNUAL EXAM MAY ONLY BE BILLED ONCE PER 365 DAYS
810	THE MAXIMUM OF $200 PER DAY, PER CLIENT, FOR MH SERVICES HAS BEEN MET
811	AMBULANCE TRIPS LIMITED TO ONE UNIT PER DAY PER PROVIDER
812	GROUP THERAPY SESSIONS MUST LAST A MINIMUM OF 1 HOUR
813	DISCHARGE DAY MANAGEMENT LIMITED TO ONE PER HOSPITAL STAY PER RECIPIENT
814	CHEMOTHERAPY TREATMENT IS LIMITED TO ONE UNIT PER DAY AND 4 UNITS PER WEEK
815	DIAGNOSIS AND EVALUATION LIMITED TO 4 HOURS/MONTH OR $192/MONTH PER RECIPIENT
816	GROUP THERAPY IS LIMITED TO 10 HOURS PER WEEK.
817	PSYCHOTHERAPY IS LIMITED TO FIVE HOURS PER WEEK.
818	DAY ACTIVITY IS LIMITED TO FIVE PER WEEK.
819	CODE CANNOT BE PAID UNLESS PRIMARY SURGERY IS AUTHORIZED & COED SUBSTANTIATED
820	THIS PSYCHOLOGICAL/PSYCHIATRIC PROC MAY ONLY BE BILLED IN ONE UNIT OF SERVICE.
821	PSYCHOTHERAPY PAYMENTS APPROACHING MAX. ALLOWED. IF EXTENSION NEEDED, APPLY NOW

822	RECIPIENT CANNOT BE CLASSIFIED AS BOTH MH AND MR FOR THE SAME DATE OF SERVICE
823	MAXIMUM OF $500 PER YEAR LIMIT HAS BEEN REACHED
824	PROCEDURE CODE LIMITED TO 5 HOURS PER YEAR
825	HISTORY SHOWS OB CARE GIVEN BY ONE PROVIDER. REBILL THE APPROPRIATE TOTAL CODE
826	ADULT DENTAL BENEFITS APPROACHING MAXIMUM ALLOWED AMOUNT FOR THIS RECIPIENT
827	ADULT DENTAL"S MAXIMUM ALLOWED AMOUNT HAS BEEN REACHED FOR THIS RECIPIENT
828	PROCEDURES LIMITED TO 5 HOURS PER YEAR
829	TOTAL OB CARE CANNOT BE BILLED BECAUSE PRENATAL VISITS ALREADY PAID
830	PRENATAL VISITS AND TOTAL OB CARE CANNOT BE BILLED FOR THE SAME PREGNANCY
831	TOTAL OB CARE CANNOT BE PAID BECAUSE PARTIAL OB CARE ALREADY PAID
832	SECOND,ETC.CONSULT FOR RELATED CONDITIONS SHOULD BE BILLED WITH "FOLLOW-UP" CODE
833	AMBULANCE CERTIFICATION FORM MISSING/INVALID.
834	AN MD PROVIDING ACTUAL TREATMENT CANNOT ALSO BILL AS A CONSULTANT
835	PLEASE RESUBMIT WITH DATE AND PROVIDER OF ORIGINAL SURGERY
836	POST-OP CARE INCLUDED IN SURGICAL SERVICE FOR 30 DAYS FOLLOWING SURGERY.
837	NEW PATIENT PROCEDURE CODES ARE NOT ALLOWED FOR ESTABLISHED PATIENTS.
838	MEDICAL BENEFITS NOT ALLOWED ON SAME DAY AS SURGERY
839	INITIAL CONSULTATION LIMITED TO ONE PER DIAGNOSIS PER PROVIDER
840	PLEASE RESUBMIT WITH COPIES OF THE APPROPRIATE INITIAL CONSULTATION RECORDS
841	CAST APPLICATION INCLUDED IN PRICE PAID FOR FRACTURE WITH REDUCTION FOR 30 DAYS
842	POSTPARTUM CARE LIMITED TO ONE PER SIX MONTHS
843	PRENATAL VISITS LIMITED TO 15 PER 280 DAYS
844	POSTPARTUM CARE LIMITED TO ONE PER SIX MONTHS FOR NURSE MIDWIVES
845	THESE SERVICES INCLUDED IN PREVIOUSLY PAID ECG WITH STRESS TESTING
846	MORE THAN ONE ADMISSION CODE TO SAME FACILITY/SIMILAR DIAGNOSIS/30 DAYS NEEDS PA
847	WEEKLY RADIATION THERAPY MANAGEMENT IS LIMITED TO 5 UNITS PER 7 DAYS
848	ADMISSION CODES LIMITED TO ONE PER HOSPITAL PER 30 DAYS FOR SIMILAR DIAGNOSES
849	PA REQUIRED FOR MORE THAN TWO CONTACT LENSES PER LIFETIME
850	ONE INTRAOCULAR LENS ALLOWED PER LIFETIME
851	THE MAXIMUM UNITS FOR REHAB EVALUATIVE SERVICES HAS BEEN MET FOR CALENDAR YEAR
852	SINGLE EXTRACTION LIMIT TO ONE/DAY. USE DIFF PROC FOR SECOND & MORE EXTRACTIONS
853	SKILLED NURSING AND INTERMEDIATE CARE FACILITY VISITS ARE LIMITED TO ONE/WEEK
854	PRENATAL VISITS LIMITED TO 15/YEAR FOR NURSE MIDWIVES
855	INDIVIDUAL SERVICES AND WAIVER CANNOT BE BILLED FOR OVERLAPPING DATES
856	FOR 2ND ADMIT/MONTH/SIMILAR DIAGNOSIS, USE SUBSEQUENT HOSP. CARE CODE
857	SERVICE INCLUDED WITHIN ROUTINE NEWBORN CARE
858	PROCEDURE CODES W1000 AND A9030 CANNOT BE BILLED ON THE SAME DATE OF SERVICE
859	ROUTINE NEWBORN CARE LIMITED TO ONE PER DELIVERY
860	NEWBORN RESUSCITATION LIMITED TO ONE PER DELIVERY
861	THIS HUD/HHS IS NO LONGER A COVERED SERVICE
863	PROCEDURE LIMITED TO 1 UNIT PER DATE OF SERVICE
864	PLEASE RESUBMIT WITH COPIES OF BOTH ADMISSION HISTORIES
865	ONLY ONE OFFICE/EPSDT VISIT PERMITTED PER DAY FOR SAME RECIPIENT, SAME PROVIDER
866	PROCEDURE LIMITED TO ONE PER DOS
867	HEMODIALYSIS CODES LIMITED TO 3 UNITS WITHIN 7 DAYS
869	ALLERGY TESTING PROCEDURE LIMITED TO ONE UNIT PER DATE OF SERVICE
870	BILL ONLY ONE CODE PER GROUP FOR TOTAL # OF TESTS DONE; UNITS=1
871	ALLERGY VACCINES MAY ONLY BE BILLED IN ONE UNIT PER DATE OF SERVICE
872	PROCEDURE CODE LIMITED TO 1 UNIT PER DATE OF SERVICE

873	PROCEDURE CODE LIMITED TO 1 UNIT PER DATE OF SERVICE
874	PROCEDURE CODE LIMITED TO 1 UNIT PER DATE OF SERVICE
875	PAYMENT REDUCED TO PSYCHOTHERAPY LIMITATION OF 1 UNIT PER DAY
876	MD CANNOT BILL NEWBORN ADMIT AND SUBSEQUENT HOSPITAL VISITS FOR NORMAL NEWBORN
877	PROCEDURE LIMITED TO TWO UNITS PER DAY
878	GENERAL PSYCHOTHERAPY LIMITED TO 1 UNIT PER DAY OVER 21, 2 UNITS UNDER 21
879	DHS GENERAL PSYCHOTHERAPY LIMITED TO 28 UNITS PER WEEK
880	CONSULTATIONS LIMITED TO ONE UNIT PER DOS
881	SA REHAB VISITS LIMITED PER 365 DAYS
882	DHS DAY HOSPITAL LIMITED TO EIGHT UNITS PER DAY
883	MH DAY TREATMENT LIMITED TO ONE UNIT PER DAY
884	PROCEDURE CODE LIMITED TO 5 UNITS PER CALENDAR WEEK
885	MR MILEAGE LIMITED TO 2 UNITS PER DAY
887	ECHOCARDIOGRAPHY LIMITED TO ONE PER DATE OF SERVICE.
888	MR/REHAB GENERAL PSYCHOTHERAPY IS LIMITED TO 7 HOURS PER WEEK
889	THIS TOS 5 AUDIOMETRIC TEST CAN ONLY BE BILLED IN UNITS OF ONE
890	MR/REHAB DIAGNOSIS & EVAL. IS LIMITED TO 30 HOURS PER YEAR
893	SPAN OF DAYS FOR MILEAGE DOES NOT EQUAL DATES OF CLINIC VISITS.
894	MR DAY TREATMENT IS LIMITED TO 1 UNIT PER DAY
895	MR DAY TREATMENT IS LIMITED TO 5 UNITS PER WEEK
896	WAIVER SERVICES LIMITED TO ONE UNIT PER DOS
897	THE MAXIMUM LABOR TIME ALLOWED FOR SEATING SYSTEMS IS 5 HOURS
898	THE MAXIMUM LABOR TIME ALLOWED FOR SEATING SYSTEM MODIFICATIONS IS 3 HOURS
899	TRAINING/COUNSELING BY MD LIMITED TO ONE PER RECIPIENT LIFETIME, ANY PROVIDER
900	ROUTINE VENIPUNCTURE FOR SPECIMEN(S) COLLECTION LIMITED TO 1 UNIT/DAY/PROVIDER
901	ENCOUNTER VISITS LIMITED TO ONE PER DAY PER PROVIDER
902	P9001 LIMITED TO ONE UNIT/DAY FOR SAME PROVIDER
903	POS REVERSAL
904	P9650 LIMITED TO ONE UNIT/DAY FOR SAME PROVIDER
905	CLAIM DENIED-DUP LOCAL CDE TO NAT"L CDE SUBMITTED FOR DOS
906	WAIVER CODES X8100-X8122 CANNOT BE BILLED WITH PROCEDURE CODES X3800-X3888
909	THE MOTHER"S ADMISSION IS INCLUDED WITHIN THE OB/DELIVERY REIMBURSEMENT
910	VISUAL ANALYSIS EXAMS LIMITED TO ONE PER 730 DAYS
911	PROCEDURE X2887 CANNOT BE BILLED WITH PROCEDURE X2876
913	REFRACTION EXAM LIMITED TO ONCE PER 730 DAYS
914	THE MAXIMUM ALLOWED OF 3 ROOT CANALS PER ADULT RECIPIENT LIFETIME HAS BEEN MET
915	PROCEDURE X3887 CANNOT BE BILLED WITH PROCEDURE X3871
919	P9600 AND 36415 CANNOT BE BILLED FOR SAME RECIPIENT, SAME DOS
923	THIS MODIFIER NOT ALLOWED FOR RECIPIENT AGE
925	MH/REHAB EMERGENCY CARE PER 30 DAY LIMIT HAS BEEN PAID
926	PRESCRIBER IDENTIFICATION MISSING/INVALID
928	RURAL HEALTH CLINIC AND FQHC ENCOUNTERS LIMITED TO 5 PER 30 DAYS
932	CEPHALOMETRIC X-RAY IS LIMITED TO ONCE IN 730 DAYS
933	DIAGNOSTIC MODELS ARE LIMITED TO ONE PER 730 DAYS
934	DIAGNOSTIC PHOTOGRAPHS LIMITED TO ONCE IN 730 DAYS
938	TMJ SPLINT LIMITED TO ONE PER JOINT PER 730 DAYS
939	MILEAGE IS COVERED ONLY WHEN CLINIC,CASE MANAGEMENT, OR REHAB SVCS. ARE PROVIDED
940	INITIAL ORAL EXAM LIMITED TO 1 PER SAME PROVIDER PER LIFETIME
941	PERIODIC ORAL EXAM LIMITED TO ONE PER 180 DAYS

942	ONLY TWO ORAL EXAMS (INITIAL AND/OR PERIODIC) ARE COVERED PER CALENDAR YEAR
943	COMPLETE SERIES RADIOGRAPHS LIMITED TO ONCE IN 1460 DAYS
944	MAXIMUM ALLOWED FOR INTRAORAL FILMS PER DOS, PER PROVIDER
947	PANORAMIC FILM LIMITED TO ONE PER 1460 DAYS BY THE SAME PROVIDER
948	DENTAL PROPHYLAXIS LIMITED - TWO PER CALENDAR YEAR
949	FOUR PINS FOR RESTORATION LIMITED TO ONE/TOOTH/365 DAYS, ANY PROVIDER
950	DME CANNOT BE RENTED FOR LONGER THAN 3 MONTHS UNLESS MEDICAID APPROVAL ATTACHED.
951	BOTH THE DATE OF PRESCRIPTION AND THE DATE OF PROVIDER"S SIGN. NEEDED TO PROCESS
952	PLEASE RESUBMIT ON DME/SUPPLIES CLAIM FORM
953	CLAIM DENIED FOR MULTIPLE ERRORS. ANY QUESTIONS PLEASE CONTACT COMMUNICATIONS
954	CLAIM/DETAIL DENIED. MEDICAID COLUMN AMOUNTS MUST BE ENTERED. CORRECT AND REFILE
955	RESTORATIVE TREATMENT LIMITED TO ONCE PER TOOTH/TOOTH SURFACE PER 365 DAYS.
956	DIAGNOSIS(ES) USED DO(ES) NOT RELATE TO ITEM(S)/SERVICE PROVIDED.
957	DENIED. FIRST MONTH"S "TENS" SUPPLIES INCLUDED IN RENTAL FEE FOR E0730-RR.
958	RESUBMIT WITH DATE ITEM PURCHASED (OR RENTAL START DATE) AND PROVIDER OF ITEM.
959	ENTERAL SUPPLIES ARE LIMITED TO HIGH TECH PROVIDERS, WITH A PA FROM MEDICAID
960	RESUBMIT WITH YOUR LABOR RATE (PER HOUR) AND THE TOTAL TIME BEING BILLED.
961	PLEASE RESUBMIT.UNITS SHOULD EQUAL NO. OF TOTAL ITEMS IN ALL INDIVIDUAL PACKAGES
962	DHS AUTHORIZATION REQUIRED WHEN SERVICE PROVIDED TO RECIPIENT UNDER 18 YEARS OLD
963	PLEASE ITEMIZE CHARGES TO INDIVIDUAL ITEMS BILLED ON THIS DME CLAIM & RESUBMIT
964	RESUBMIT WITH INVOICE AND COPY OF WARRANTY
965	INAPPROPRIATE PROCEDURE CODE. PLEASE REFER TO DME MANUAL
966	SERVICE DATE IS BEFORE AUTHORIZED DATE IN PA NUMBER.
967	PLEASE RESUBMIT W/COPY OF ORIGINAL CLAIM YOU USED TO OBTAIN PRIOR AUTHORIZATION.
968	MEDICAL NECESSITY FORM DOES NOT DOCUMENT NEED OF ITEM
969	QUANTITY PROVIDED PER 30 DAYS EXCEEDS NORMAL USAGE
970	PLEASE GIVE ITEMIZED LIST OF LABOR AND PARTS CHARGES
971	THESE SUPPLIES ARE INCLUDED WITHIN THE REIMBURSEMENT OF THE EQUIPMENT RENTAL
972	WHEELCHAIR PRICING REQUIRES BRAND NAME AND MODEL NUMBER
973	LENGTH OF NEED INDICATED ON THE MED. NECESSITY FORM CONTRADICTS BILLING RENTAL.
974	COMPLETE MED SUPPLIES SECTION OF MED. NEC. FORM AND INDICATE AVG. MONTHLY USAGE.
975	PLEASE RESUBMIT WITH MANUAFACTURER"S INVOICE OR SUGGESTED LIST PRICE
976	DENIED. QUANTITY PROVIDED EXCEEDS ALLOWED/NORMAL AMOUNT(S).
977	THE DATE THAT THE PHYSICIAN"S CERTIFICATION WAS COMPLETED IS ILLEGIBLE/INVALID.
978	RENTAL DENIED. CONSIDERATION OF PURCHASE IS INDICATED DUE TO LONG TERM NEED.
979	QUANTITY/UNITS BILLED EXCEED(S) AMOUNT APPROVED ON MEDICAL NECESSITY FORM
980	PA OR EXPLANATION REQUIRED TO JUSTIFY EXCESSIVE QUANTITIES/UNITS
981	DOCUMENTATION INDICATES TEMPORARY NEED. REBILL FOR RENTAL INSTEAD OF PURCHASE
982	ANNUAL PHYSICAL EXAM LIMITED TO ONCE PER 365 DAYS
983	EFFECTIVE 1-1-88, SERVICE COVERED UNDER SOLE-SOURCE RESPIRATORY CONTRACT
984	ONLY SOLE-SOURCE CONTRACTOR ALLOWED OXYGEN IN NURSING HOME
985	NEW AOPA CODE IN EFFECT FOR DOS 4-1-88 AND AFTER. REFER TO YOUR UPDATED LISTING.
986	DENTAL SEALANTS TO ONCE PER PERMANENT TOOTH, RECIPIENT UNDER 21, ANY PROVIDER
987	CODE Y9873 NEEDS MD PRESCRIPTION (DOSAGE,FREQ.,# DAYS) AND NATIONAL DRUG CODE #
988	EXPLANATION/DOCUMENTATION NEEDED TO JUSTIFY MORE EXPENSIVE ITEM
989	THERAPEUTIC FOSTER CARE (-TF) AND FAMILY BASED (-FB) SERVICES ARE EXCLUSIVE
990	RECIPIENT ALLOWED MAXIMUM OF 124 UNITS IN A SIX MONTH PERIOD
991	RECIPIENT ALLOWED A MAXIMUM OF 1 UNIT PER EIGHT MONTH PERIOD
993	CASE MANAGEMENT LIMITED TO $600 PER CALENDAR MONTH

994	RECIPIENT NOT ENROLLED IN RITESHARE FOR DATES OF SERVICE BILLED ON CLAIM
995	RECIPIENT PARTIAL ENROLLMENT IN RITESHARE FOR DATES OF SERVICE BILLED ON CLAIM
996	PLEASE RESUBMIT ACCORDING TO FQHC ENCOUNTER BILLING GUIDELINES
997	WE HAVE SPLIT AND REBATCHED YOUR CLAIM. IT WILL SHOW AS PENDING ON YOUR NEXT RA
998	CLAIM DENIED AT PROVIDER"S REQUEST
999	EDS WILL RESUBMIT. DO NOT RESUBMIT.