Status Legend: D = Deny; E = EOB Message; O = Off (Inact.); T = Test(Inact.)

001 - INVALID CLM TYP MOD - CLM-TYP-MOD must equal 2 or 4; it must be numeric and greater than 0; it must be a valid Julian date . **Field** - FORMER ICN; **Pend Reason** - FORMER-ICN-NO-ERR (LAM2D030) **STATUS -** T

002 - INVALID PROVIDER NO - Must be numeric and greater than 0. **Field -** PROV-NO; **Pend Reason -** PROV-NO-ERR(LAM2D030)

003 - RECIPIENT # INVALID - Must be numeric and greater than 0000000000000. **Field -** RECIP-NO; **Pend Reason -** RECIP-NO-ERR(LAM2D030)**STATUS -** D

004 - INVALID OPERATOR CODE - Operator code must be present. **STATUS -**O

005 - INVAL SERV FROM DATE - Year numeric month is between 01 and 12; Day is valid for month less than current date; Service from date is greater than current date. **Field -** SERVICE-FROM-DATE; **Pend Reason -** SERV-FROM-DTE-GT-DTE-PROCESSED(LAM2D030)**STATUS -**D

006 - INVAL SERV THRU DATE - Must be numeric and greater than 0. **Field -** SERVICE-THRU-DATE; **Pend Reason -** INVALID-OR-MISS-SERV-THRU-DATE(LAM2D030)**STATUS -**D

007 - SERV THRU LT SERV FM - The Service Thru Date is less than Service From Date. **Field -** SERVICE-THRU-DATE; **Pend Reason -** SERV-THRU-DT-LT-SERV-FROM-DTE(LAM2D030)**STATUS -**D

008 - SERV FRM GT ENTR DTE - The Service From date must be equal to or less than the Julian date on the ICN number.

009 - SERV THR GT ENTR DTE - The Service Thru date must be equal to or less than the Julian date on the ICN number. **Field -** SERVICE-THRU-DATE; **Pend reason -** SERV-THRU-DTE-GT-DTE-PROCESSED(LAM2D030)

010 - INV PRIOR AUTH DATE - If present, must be numeric and in a valid date format. **Field -** PA-DATE; **Pend reason -** INVALID-PRIOR-AUTH-DATE(LAM2D030)

011 - INVALID TPL INDICATR - Must be Y, N, or space. **Field -** GROUP NAME, OTHER INSURED'S NAME, PAYMENT SOURCE, DRUG COVERAGE OTHER THAN TITLE XIX; **Pend Reason -** TPL-IND-ERR(LAM2D030)

012 - INVALID LINE TPL AMT - If ICN 6-8 = 999 and CLAIM-TYP-MOD is 2, then must be numeric and greater than zeroes. **Field -** LINE-TPL-AMOUNT; **Pend Reason -** INVALID-OR-MISS-LINE-TYP-AMT(LAM2D030)**STATUS -**O

013 - INVALID TOT TPL AMT - Total TPL amount not numeric. **STATUS -**O

014 - INVALID SPEND DOWN - Spend down form must be attached and the characters entered in this field must be numeric.

015 - INVALID ACCIDENT IND - Must be Y, N, or space. **Field -** ; **Pend Reason -** ACCIDENT-INDICATOR- ERR. **STATUS** -D

016 - INVALID ACCID IND - Must be Y, N, or space. **Field -** ACCID-IND; **Pend Reason -** ACCIDENT-INDICATOR-ERR

017 - INVALID EPSDT IND - Must be Y, N, or space. If space, default is N. **Field -** EPSDT-IND; **Pend Reason -** EPSDT-INDICATOR-ERR

018 - INVALID PRIM DIAGNOS - DIAG-BYTE 1 = Numeric or V; DIAG-BYTE 2-5 = Numeric; DIAG-BYTE 2-3 = Numeric; DIAG-BYTE 4 = Numeric or space; DIAG-BYTE 5 = Numeric or space. **Field -** DIAG OR SEC DIAG; **Pend Reason -** INVALID-PRIM-DIAG. **STATUS** -O

019 - INVALID SEC DIAGNOS - DIAG-BYTE 1 = Numeric or V; DIAG-BYTE 2-5 = Numeric; DIAG-BYTE 2-3 = Numeric; DIAG-BYTE 4 = Numeric or space; DIAG-BYTE 5 = Numeric or space. **Field -** DIAG OR SEC DIAG; **Pend Reason -** INVALID-SEC-DIAG. **STATUS** -O

020 - INVAL/MISS DIAG CODE - Invalid or missing Diagnosis **code. STATUS** -D

021 - INVALID FORMER REFNO - Former reference number must be numeric and Julian date must be greater than 0 and less than 366.

022 - INVALID BILLED CHARGES - Must be numeric and greater than 0. **Field -** BILLED-CHARGES; **Pend reason -** BILLED-CHARGES-ERR(LAM2D030). **STATUS** -D

023 - IN PARTIAL RECIP - Last five characters of the recipient's last name or the recipient's first initial must be present. **Field -** RECIP-NAME ; **Pend Reason -** MISSING-RECIPIENT-OR-INT(LAM2D030). **STATUS** -D

024 - INV BILLING PROV NO - Must be numeric and greater than 0. **Field -** BILL-PROV-NO; **Pend Reason -** INVALID-BILL-PROV-NO(LAM2D030).

025 - INV EOB/OVERRIDE CDE - EOB/Override code must be numeric. **STATUS** -O

026 - INVALID TOT DOC CHG - Must be numeric - **Field** TOT-DOCUMENT-CHARGE**; Pend Reason -** INVALID-TOTAL-DOC-CHG (LAM2D030).

027 - PROC NEEDS DOCUMENT - Procedure codes must be substantiated by documentation. **STATUS** -E

028 - INVAL/MISSING PROC CODE - Procedure code must be valid and present. **Field -** PROC-CODE **; Pend Reason -** PROC-CODE-ERR. **STATUS -**D

029 - DOS 12 MO - The Service From date must not be older than 12 months. The date must be less than or the same as the date processed. the year of service must be less than or the same as the current year. **Fields -** 22 STATEMENT COVERS PERIOD-FROM/THRU, DATES OF SERVICE, 19 STATEMENT COVERS PERIOD -FROM/THRU

030 - SERV THRU DT TOO OLD - Service through date must not be more than 2 years old. **STATUS -**D

031 - NOT EMC ELIGIBLE - Provider must be approved for EMC by state OFS. **STATUS -** D

032 - EOB/CARR.CD MISMATCH - EOBs attached/carrier code must match. **STATUS -**E

033 - NEED EOB-CARR/RECIP. - EOB is needed for each carrier indicated on resource file. **STATUS -**E

034 - 22 MOD. NOT JUSTIFIED - 22 Mod. Services not justified/paid at unmodified rate. **STATUS -**E

035 - REBILL CORRECT HCPC - ASC,OP FAC/Phys. billed different code. Rebill correct HCPC. **STATUS -**D

036 - SUB VOID, REBILL ANES - Submit void then rebill anesthesia.

037 - MEDICARE ADJUSTMENT - Medicare adjustment/void, adjustment or adjust Medicare claim.

038 - 99297-52 NICU REDUCE - 99297-52 NICU paid at reduced rate.

039 - MOD. NOT USED FOR CLM - Modifier not used to process claim.

040 - INV ADMISSION DATE - Must be numeric, month must be between 01 - 12 , day must be valid for the month given. **Field -** ADMISSION DATE

041 - ADMIT DTE GT SERV FM - The date of admission should not be after the Service From date. **Field -** ADMISSION DATE, STATEMENT COVERS PERIOD - FROM/THRU

042 - INVALID UB92 BILL CD - Must be numeric and have a valid code. **Field -** BILL TYPE

043 - INV ATTENDING PHYS - Attending physician number must be present and numeric. **Field -** ATTENDING PHYSICIAN ID, PROVIDER NUMBER, ATTENDING PHYSICIAN NAME/PROVIDER NUMBER, ATTENDING DENTIST'S SIGNATURE

044 - INV NATURE OF ADMIT - Nature of Admission must be present and must be 1)emergency, 2)urgent, 3)elective, or 4)newborn(delivery). **Field -** ADMISSION TYPE

045 - INVALID PAT STATUS CDE - Patient status on the UB82 claim form must be present and 01, 02, 03, 04, 05, 06, 07, 20, or 30. **Field -** STAT; **Pend Reason -** INVALID PAT STATUS CDE

046 - INV PAT STAT DTE - The patient status must meet the following criteria: 1) All fields must be numeric; 2)Month must be between 01 and 12; and 3)The day must be valid for the month given. **Field -** PATIENT STATUS

047 - PAT STAT DTE GT THRU - The patient status date must not be later than the Service Thru date. Patient status date should be the latest date on the claim. **Field -** STATEMENT COVERS PERIOD - FROM/THRU, PATIENT STATUS

048 - INVALID/MISS PROC - The surgical procedure must accompany a surgical date. A surgical code must accompany a revenue code indicating surgery. The revenue codes are 360-362, 369-390, 374, 379, 710, 719. **Field -** PROCEDURES AND DATES

049 - INV/CONFLIC SURG DTE - The surgical date must be numeric, the month must be from 01 - 12 and the day must be valid for the month. If a surgical procedure is shown on a claim, a date must also be entered. **Field -** PROCEDURES AND DATES

050 - INV BLOOD NOT REPL - The Blood Not Replaced field must be blank or numeric. **Field -** BLOOD (PINTS) NOT RP

051 - INV BLOOD/PNT CHG - Must be numeric. **Field -** S-UNITS

052 - INV TOT BLOOD CHG - The pints of blood replaced plus the pints of blood not replaced should equal pints of blood furnished. **Field -** BLOOD (PINTS) FURNISHED, BLOOD (PINTS) REPL, BLOOD (PINTS) NOT RP

053 - INV ACCOMMODATION DAY - Valid characters must be entered in the accommodation revenue code (UB82) and the revenue units. The codes are 100, 101, 110-117, 119-127, 129-137, 159, 160, 167, 169-172, 175, 179-185, 189-204, 206-214, and 219. **Field -** R CODE, S-UNITS

054 - INVALID ACCOM RATE - The accommodation rate must be entered and be numeric. **Field -** R CODE, DESCRIPTION (RATE)

055 - INV ACCOMM/ANCILL CHG - The revenue code and the covered charge or non-covered charge must be present. **Field -** R CODE, TOTAL CHARGES, TOTAL NON-COVERED CHARGES

056 - INV ANCILLARY CHARGE - Ancillary charges are missing or invalid. **STATUS -**O

057 - TOT CHG/SUM DIFFER -The sum of the charges must equal the total charges entered. **Field -** STATEMENT OF SERVICES RENDERED, TOTAL CHARGE, TOTAL CHARGES, 17f CHARGE, 17e CHARGE

058 - INV NON COV CHARGES - Must be numeric. **Field -** TOTAL NON-COVERED CHARGES

059 - NET BILL NEQ CALC - The calculated charges must equal the net billed charges coded on the claim. **Field -** TOTAL CHARGES, EST AMOUNT DUE, TOTAL CHARGE, TOTALS, USUAL AND CUSTOMARY FEE

060 - INV COVERED DAYS - The total of covered days plus non-covered days must be equal to the difference of Thru date minus From date. If the patient status is "30" (still patient), a "1" is added to this calculation. **Field -** STATEMENT COVERS PERIOD - FROM/THRU, COV D, NCD

061 - INVALID PSRO DATE - The PSRO/UR code is 3 and the PSRO From or PSRO Thru date must be valid. **Field -** PSRO/UR FROM DATE, PSRO/UR THRU DATE

062 - INVALID APPROVED DAYS - Must be numeric.

063 - INVALID TOTAL CHARGE - Must be numeric. **Field -** TOTAL CHARGES

064 - INVALID NET AMOUNT - Must be numeric. **Field -** TOTAL CHARGES, BALANCE DUE, NET BILLED

065 - INVL SIGNATURE IND - Must be Y. N or space. **Field -** SIG-IND; **Pend Reason -** INVALID-SIGNATURE -INDICATOR

066 - INV BENEFIT EXHAUST - Must be Y, N, or space. **Field -** ASG BEN; **Pend Reason -** INVALID-BEN-EXHAUST ERR

067 - INVALID NON-COVERED - Non-covered days must be present and in a numeric format. **Field -** NCD

068 - INV SOURCE ADMISN - Source of admission must be 1 through 8. If type of admission is 4 (newborns), the source must be 2 through 4. **Field -** ADMISSION SOURCE, ADMISSION TYPE. **STATUS -**O

069 - INV OCCUR DATE - The occurrence date must be present and a valid date. **Field -** OCCURRENCE CODES

070 - INV STMT COVERS FROM - Statement covers From date must be present, numeric and six digits long. **Field -** STATEMENT COVERS PERIOD - FROM/THRU. **STATUS -**D

071 - INV STMT COVERS FROM - From date must be present, numeric and six digits long. **Field -** STATEMENT COVER PERIOD - FROM/THRU

072 - INV STMT COVER THRU - Thru date must be present, numeric and six digits long. **Field -** STATEMENT COVERS PERIOD - FROM/THRU

073 - STMT FRM LT SERV FRM - Start of service cannot be before From date. **Field -** DATE OF SERVICE, STATEMENT COVERS PERIOD FROM/THRU

074 - STMT THRU GT SRV THR - Date of service cannot be after Thru date. **Field -** STATEMENT COVERS PERIOD - FROM/THRU, DISCHARGE

075 - INVALID TYPE SERVICE - Type of service for ambulance must be 3 or 9. **Field -** TYPE OF SERVICE (3) NON-EMERGENCY OR (9) EMERGENCY

076 - INV DME PA AMOUNT - Prior Authorization field must be numeric.

077 - NEED REV CODE DESCRP - Revenue code requires written description. **STATUS -**E

078 - RESUB W/DOCUMENTS - Medical necessity must be established for a resubmitted claim by op/path/hist/picture. **STATUS -**D

079 - FOUND NO PSRO CODE - PSRO code must be present and valid. **STATUS -**D

080 - INVALID LAB INDICATOR - Must be a Y, N or a space. **Field -** OUTSIDE LAB

081 - INVALID STATUS DATE - Date Discharged, Date of Death, or Visits Exhausted must be present, numeric and valid. **Field -** PATIENT STATUS

082 - INVALID STATUS CODE - Patient status must be valid (A-D).

083 - INVALID SERVICE CODE - Valid codes are A = Skilled Nursing Care; F = Home Health Aide; K = Medical Supplies; and P = Physical Therapy. **Field -** SERVICE CODE

084 - INVALID TREAT PLACE - The place of treatment code must be entered and a valid code. **Field -** PLACE OF SERVICE **Pend Reason -** INVALID-OR-MISS-PLACE-TREAT (LAM2D030). **STATUS -**D

085 - INVALID UNITS/VISITS - Units, visits, studies must be valid and present. Fields - UNITS, VISITS, QUANT. **Pend Reason -** INVALID-OR-MISS-U-V-S. **STATUS -**D

086 - INVALID PA AMOUNT - Prior Authorization amount must be present and valid. **STATUS -**O

087 - INVALID PA DATE - Prior Authorization date must be present and valid. **STATUS -**O

088 - INVALID ORIGIN CODE - Origin code must be valid. **STATUS -**O

089 - INVALID DESTINATION - Destination code must be valid. **STATUS -**O

090 - REF PROV NO NOF - Referring provider number must be on file. **STATUS -**O

091 - INVD REF PROV INDCTR - Must be Y, N or blank. **Field -** NAME OF REFERRING PHYSICIAN, ID NUMBER OF REFERRING PHYSICIAN

092 - INVALID PROC MODIFIER - Must be blank or be on the approved list of modifiers. Modifiers include: 22, 24, 26, 52, 55, 56, 75, 76, 77, 23, 30, 47, 50, 54, 66, 80, 81, 90, 99, 20, 25, 51, 62, 82, AA, AB, AC, AD, AE, AF, AG, AH, AI, AP, AR, AS, AT, CC, DD, EE, EH, EP, ER, ET, HE, HH, HR, HT, LL, LT, PH, PS, RE, RH, RP, RR, SH, TC, TS, UE, UC, VP, XX, YY, ZZ, LS, NU, W5 WA, WC, WD, WE, WI, WN, WS, WX, XA, XB, XC, XM, XO, Y5, ZB, ZC, ZD, ZS. **Field -** MODIFIER **Pend Reason -** INVALID-PROC-MOD . **STATUS -**O

093 - REVENUE CODE MISSING - Revenue code must be present when there is a covered or non-covered charge. **Field -** R CODE, TOTAL CHARGES, TOTAL NON-COVERED CHARGES

094 - MISSING PINTS BLOOD - When a revenue code of 380 - 389 is present,, furnished pints of blood must be present. **Field -** R CODE, BLOOD (PINTS) FURNISHED

095 - FROM THRU NOT EQUAL - The condition code is 40 (Same Day Transfer) and the statement From and Thru dates must be equal. **Field -** CONDITION CODE, STATEMENT COVERS PERIOD - FROM/THRU

096 - REVENUE CHG MISSING - When a revenue code is present, the covered charge/non-covered charge must be present. The revenue charge must be equal to the units times the revenue rate. **Field -** R CODE, TOTAL CHARGES, TOTAL NON-COVERED CHARGES, DESCRIPTION, S-UNITS

097 - NON-COVCHG GREATER THAN BILLCHG - The amount entered should not be greater than the amount entered for total charges.

098 - BILL-CODE-REQ-MC-CHG - When the inpatient code for bill is 2 an entry must be made in the Prior Payments field. **Field -** PRIOR PAYMENTS

099 - DME COVERAGE ONLY - The item is covered under Durable Medical Equipment program only.

100 - PROC CD MUST 5 DIGIT - The procedure code must be 5 numeric characters. **STATUS -**O

101 - INVALID EMER IND - Must be Y, N or space. **Field -** EMERGENCY CERTIFICATION **Pend Reason -** INVALID-EMER-IND (LAM2D030).

102 - INVALID SURFACE - Tooth surface code must be entered and must be the two-position alpha-numeric code. **Field -** SURFACE. **Pend Reason -** INVALID-TOOTH-SURFACE (LAM2D030).

103 - INVALID TOOTH CODE - Tooth code must be entered and must be entered an a valid combination of alpha-numeric characters. **Field -** DIAGRAM. **Pend Reason -** INVALID-TOOTH-CODE(LAM2D030).

104 - INVALID PROSTHESIS - Must be Y, N, or space. **Field -** REMARKS FOR UNUSUAL SERVICES, COMMENTS. **Pend reason -** INVALID-PROSTHESIS-IND (LAM2D030).

105 - REF MUST BE MGR - Referring must be Case Manager. **Field -** REFERRAL DATA, ATTENDING PROVIDER NUMBER

106 - BILL PRV NOT PCP - Billing provider must be PCP or service must be authorized by PCP.

107 - PARTIAL HOSP NOT PAY - Partial Hospital not payable for Medicaid only.

108 - PRV TYPE AGE RESTRIC - Prov Type Services must be covered for recipient this age.

109 - NOT HCBS LOCKED IN

110 - REBILL OB/ABORT D&C - Rebill OB or abortion D&C CPT code with reports

111 - CHANGING AGAIN - This is a changed error. **STATUS -**D

112 - AUTH PORT X-RAY - Document or edit override code for portable x-ray must be present. Remittance advice message is 'Certification for portable x-ray attached."

113 - INVALID CK DIGIT - Provider check digit must be valid. **STATUS -**O

114 - INV/MISSING HCPCS - HCPCS must be present and valid. **STATUS -**D

115 - HCPC CD NOT ON FILE - The HCPC code must be found on the procedure/formulary file. If the type of bill (first 2 digits) is 13, the type of service of 03. Otherwise the type of service is 08. **Field -** BILL TYPE, DESCRIPTION.

116 - DEFRA REDUCTION - Payment reduced to Medicare maximum. **STATUS -**E

117 - MAX: 2 DAYS TRSFR MHIS - Maximum of 2 days allowed to transfer MHISA patients

118 - HOSP LIMITED TO EMER - HOSP limited to emergency care and transfer of MHISA patients.

119 - INVEST, EXPER, OR NOT - Investigating, experimental or not medically necessary procedures not covered.

120 - QTY INVALID/MISSING - Zero or non-numeric character should not be entered in the quantity or units field. **Field -** QUANTITY **Pend Reason -** METRIC-QTY-ERR(LAM2D030).

121 - MISS OR INV PRESCRIB - Prescriber identification should be present and valid. **Pend Reason -** PRESCRIBING-PHYSICIAN-ERR(LAM2D030). **STATUS -**O

122 - INVALID RX DATE - The prescription date should be present and numeric. **Field -** RX DATE **Pend Reason -** RX-DATE-ERR(LAM2D030).

123 - RX SERVICE DATE - The date of service must be before the date the prescription was filled. **Field -** RX DATE, DATE RX FILLED **Pend Reason -** RX-DATE-GT-SERV-FROM-DATE (LAM2D030).

124 - INVALID DAYS SUPPLY - Days supply must be present, numeric, and greater than 0. **Field -** NO DAYS SUPPLY **Pend Reason -** RX-DAYS-SUPPLY-ERR(LAM2D030).

125 - PRESCRIP NO MISSING - Prescription number must be entered. **Field -** RX NUMBER

126 - INVALID REFILL CODE - Refill code must be numeric, greater than 5, and must be present. **Pend Reason -** REFILL-ERR(LAM2D030).

127 - MISSING NDC - The NDC code must be numeric and must consist of the following: Manufacturer Number - 5 digits long; Product Number - 5 digits long; Package - 2 digits long. **Fields -** NAT'L DRUG CODE **Pend Reason -** NATIONAL-DRUG-CODE-ERR(LAM2D030)

128 - INVALID MAC INDICATOR - The MAC override indicator must be C or blank. **Field -** MAC OVERRIDE **Pend Reason -** MAC-INDICATOR -ERR(LAM2D030).

129 - INVALID INVOICE NO - The pharmacy invoice number is required and must be greater than 0. **Pend Reason -** PRESCRIPTION-INVOICE-ERR (LAM2D030). **STATUS -**O

130 - DENY PROV. 9999999 - All providers 9999999 to be denied. **STATUS -**D

131 - PRIMARY DX NOF - Primary Diagnosis must be on file.

132 - SECONDARY DX NOF - Secondary Diagnosis must be on file.

133 - INVALID CCN

134 - DOB/CCN MISMATCH - Date of Birth and CCN must match.

137 - MEDICARE REPLACEMENT - Submit hardcopy adjustment or void claim.

138 - IN PLAN LHA SERVICE

139 - CLMS > 3/1/92: KIDMED - Claims 3/2/92 or after must be sent to KIDMED contractor.

140 - INVALID REQUEST DATE - Character entered in the Request Date field must be numeric. Year must be numeric, month must be between 01and 12, and the day must be valid for the month. **Field -** DATE OF REQUEST

141 - INVALID LAST SCREEN DATE - Characters entered in the Last Screening Date field must be numeric. The year must be numeric, the month must be between 01 and 12, and the day must be valid for the month. **Field -** DATE OF LAST SCREENING

142 - INVALID SCREEN CODE - Screen code should be I,S,P, or D. **Field -** SCREENING CODES

143 - INVALID REFERRAL IND - The value of the field must be A, B, C, or D. **Field -** REFERRAL DATA

144 - INVALID COMPLETE INDICATOR - The complete box must be checked. The indicator must be Y or N. **Field -** SCREENING COMPLETE

145 - INVALID IMMUNZTN IND - The immunization block must be checked or keyed. The field must be an A, B, C, or blank. **Field -** IMMUNIZATION

146 - INVALID SUSPECT IND - The indicator must be alpha and no more than six entries may be made. Valid entries are A through Z.

147 - REQ DATE TOO LATE - The characters in the Request Date field must not be later than the Service Thru date. **Field -** DATE OF REQUEST

148 - LAST SCREEN TOO LATE - The characters in the Screening Date field must not be after the Service Thru date. **Field -** DATE OF LAST SCREENING

149 - LTC NH 51 IND BAD - Long Term Care nursing home 51 Indicator must be present and valid. **STATUS -**O

150 - LTC CERT DTE BAD - LTC certification date must be valid and present. **STATUS -**O

151 - LTC HOSP DAYS BAD - LTC total hospital leave days must be valid and present. **STATUS -**O

152 - LTC HOME DAYS BAD - LTC total home leave days must be valid and present. **STATUS -**O

153 - LTC TOTAL DAYS BAD - LTC total leave days must be present and valid. **STATUS -** O

154 - LOC LTC CODE BAD - Level of care code 1,2,3 must be valid and present. **STATUS -** O

155 - LOC LTC TOT DAYS BAD - Level of care total leave days 1,2,3 must be present and valid. **STATUS -**O

156 - LTC LOC DYS FROM BAD - Level of care from days 1,2,3 must be present and valid. **STATUS -**O

157 - EXCEEDS LIMIT OF 8 - Co-insurance days must not exceed 8. **STATUS -**O

158 - LTC LOC NH IND BAD - Nursing home level of care indicator 1,2, or 3 must be present and valid. **STATUS -**O

160 - PRECERT NOT ON FILE - Precert number must be on file.

161 - HOSP STAY REQ PRECERT - Hospital stay requires precertification.

162 - PRECERT NOT APPROVED - Precertification has not been approved.

163 - DOS NOT PRECERT COVD - Claim DOS not precert covered.

164 - CLAIM > PRECERT LOS - Claim should not exceed precertification authorized days.

165 - SURG REQUIRES PRECERT - Surgery requires precertification.

166 - CLM RECIP NO MATCH - Claim recipient ID must match the ID on the precertification file.

167 - CLM PROV ID NO MATCH - Claim provider ID must match the ID on the precertification file.

168 - PRECERT SURG DATE ERR - Claim surgery date must match the date on the precert file.

169 - DAYS CUT TO PRECERT - Days cutback to precert approved days.

170 - PRECERT REVIEW -

171 - NO PRECERT RESUB DOC - Hospital precertification must be on file resubmission with documentation

174 - RECIP NOT XREF - A Medicaid ID must have a Medicare ID match. **Pend Reason -** RECIP-NOT-XREF(LAM2D030). **STATUS -**D

175 - CHARGES MISSING - Characters must be numeric or spaces. **Field -** TOTAL CHARGES

176 - INVALID DEDUCTIBLE - Must be numeric. **Field -** DEDUCTIBLE

177 - INVALID COINSURANCE - Characters must be present and numeric - **Field -** CO-INSURANCE

178 - INVALID BLOOD DEDUCT - Characters in the Blood Deductible Field must be present and numeric.

179 - INVALID N-C CHARGES - The Total Non-Covered Charges must be blank or numeric.

180 - INVALID ADMIT DATE - The Admission Date must be a valid date. The date must be numeric characters in the MMDDYY format. The month must be 01-12, the day must be valid for the month given, and the year must be numeric. **Field -** DATE HOME HEALTH PLAN ESTABLISHED

181 - INVALID COVERED DAYS - Covered days must be numeric or spaces. **Field -** ATTACHMENT

182 - PROC/CLAIM TYP CONFL - The procedure code used must be approved for the claim type billed.

183 - SURGERY PROC NOF - Surgical procedure must be on file.

184 - PROG IND REQ REVIEW - Program indicator requires review. **STATUS -**O

185 - KEYED INITIAL DIFFER - Keyed initial must not differ from file first initial. **STATUS -**O

186 - USE CORRECT MODIFIER - CRNA'S must bill correct modifier. **STATUS -**D

187 - CLM-DOS=PA TO PERIOD - Claim Thru Date of Service must equal Prior Authorization 30 day thru period.

188 - TRIP CANC BY DISPATCH - The trip cancelled by dispatch (Claim voided).

189 - PUT PA# IN BLOCK 23 - Correct PA number must be in block 23 on the claim.

190 - PA NO NOT ON FILE - The Prior Authorization number coded on the claim must exist on the Prior Authorization file.

191 - PROC REQUIRES PA - The procedure requires Prior Authorization and the Prior Authorization number must be present.

192 - PA NOT APPROVED - PA must be approved.

193 - DOS NOT COVERED/PA - Date on claim must be covered by Prior Authorization.

194 - CLAIM OVER PA LIMITS - Claim must not exceed Prior Authorization limits.

195 - NEED SPANNING DOS - Must have spanning DOS if billing for total authorized amount.

196 - PA RECIP NQ CLM RECI - Claim recipient ID must match the ID in the Prior Authorization file.

197 - PA PROV NQ CLM PROV - The Provider ID on the claim should match the Prior Authorization provider ID.

198 - PA PROC NQ CLM PROC - The Prior Authorization procedure must match the claim procedure.

199 - TRIP CANCELED - NONPAY - Trip cancelled non payable.

200 - PROV/ATTEND NOF - The Provider ID on the claim must match the Provider ID on the provider file. The provider number must be on file.

201 - PROVIDER NOT ELIG - The provider on the claim must be eligible (enrolled as a Medicare or HCS provider) on the date of service.

202 - PROC CLAIM TYP CONFL - The provider must be certified to bill for the claim type.

203 - PROVIDER ON REVIEW -

204 - GRP NOT ON INDIV REC - The billing provider number must be on the attending provider number's record.

205 - BILL ATTEND PROV CON - From date submitted must be greater than or equal to the From date on file. Thru date submitted must be less than to equal to Thru date on file.

206 - BILL PROV NOT ON FIL - The billing provider in group practice may be other than the servicing provider and must be on the provider file.

207 - BILL PROV NOT ELIG - The billing provider must have been eligible on the dates of service on the claim.

208 - PRESCRIB PROV ONLY - A prescribing provider cannot bill for any service.

209 - GRP MST BILL FOR PRV - Group must bill for provider. **STATUS -**D

210 - PROV PROC CONFLICT - A procedure cannot be performed by this provider under Medicaid. **Field -** PROVIDER NUMBER VS. PROCEDURE NUMBER

211 - DOS LESS THAN DOB - The date of service on the claim must not be less than the date of birth on the recipient file.

212 - PROV MUST BE INDIV - Attending provider must be individual. **STATUS -**D

213 - NDC NOT ON PROC/FORM FILE - The NDC code must appear on the procedure formulary file.

214 - PROV ALLOW 1 PROC/CM - The provider must not be paid for more than one service for a recipient on the same day.

215 - RECIPIENT NOT ON FIL - The recipient's Medicaid ID number must be found on the recipient file. The claim will recycle twice to allow for recipient file updates. If no matches are made, deny for 223.

216 - RECIPIENT NOT ELIG - Eligibility file must have a payable segment for date of service.

217 - RECIP NAME MISMATCH - The claim information must match the file record. **STATUS -**D

218 - LOCK IN RECIPIENT - Recipient or provider is restricted. **Field -** PATIENT'S NAME, PROVIDER, PATIENT NAME, DOCTOR NAME

219 - EPSDT REFER OVER 21 - EPSDT referral not valid recipient over the age of 21. **STATUS -**O

220 - SPD DOWN NOT MED NDY - Spend down amount must be medically needy. If money code is 4, recipient must be medically needy. **Field -** SPEND-DOWN AMOUNT

221 - GEN ASST - NOT COVRD - State only assistance - service not covered. **STATUS -**D

222 - SVC OVERLAPS REC ELI - Service From and Thru dates must fall within the recipient's eligibility period. **Field -** DATE(S) OF SERVICE

223 - RECYC RECIP N/O FILE - If the recycle indicator equal 2, the recipient must be on file or the system will automatically deny the claim. **STATUS -**D

224 - INVALID BIRTHDATE - A valid birth date must be present on the recipient file. **Field -** RECIPIENT FILE ONLY - WILL NOT PRINT

225 - P.E. - NOT COVERED - Claim not covered for presumed eligible recipient.

226 - INV SURGERY MODIFIER - Component of surgery paid only to teaching facilities. Modifiers are 54, 55, or 56 are used by non-teaching facilities. **Field -** PROCEDURE MODIFIER

227 - POSSIBLE 707 PEND - Claim in process. **STATUS -**O

228 - POSSIBLE 713 PEND - Claim in process. **STATUS -**O

229 - POSSIBLE 714 PEND - Claim in process. **STATUS -**O

230 - PROC REVIEW - The program has been set to suspend the claim for review when the listed procedure code is found.

231- NDC NOT ON P/F FILE - The NDC code on the claim must be on the procedure/formulary file. The NDC code on the claim must be present and entered correctly. **Field -** NATN'L DRUG CODE

232 - PROCEDURE CODE NOF - Procedure/Type of Service must be covered by the program. **STATUS -**D

233 - P/F DATE RESTRICTION - The service begin and end dates must be within the allowable time limits for this procedure as indicated on the procedure/formulary file. **Fields -** PROCEDURE AND DATES, STATEMENT COVERS PERIOD - FROM/THRU, R-CODE, DATE(S) OF SERVICE, PROCEDURE CODE, DATE OF EACH SERVICE, DATE SERVICE PERFORMED, PROCEDURE CODE, NAT'L DRIG CODE, DATE RX FILLED

234 - P/F AGE RESTRICTION - STATUS -D

235 - P/F SEX RESTRICTION - The recipient must be of the correct gender for the procedure as indicated on the procedure/formulary file. **Field -** DESCRIPTION, PROCEDURE CODES

236 - P/F PLACE RESTRICT - The place of service for the procedure must be valid as indicated by the procedure/formulary file. **Field -** PROCEDURE AND SURGICAL CODES

237 - P/F PROV SPEC RESTRT - P/F provider specialty restriction.

238 - INV DOS CALL HELP DK - Invalid date of service - call Help Desk.

239 - PRICE MISSING ON P/F - For the date of service for this procedure, the price on the procedure/formulary file must be present. **Field -** DESCRIPTION, R CODE, PROCEDURE CODE, NAT'L DRUG CODE

240 - PRICE MISSING ON U/C - When the program compares the procedure code and the date of service to the usual and customary file, there must be a price on the U&C for that date of service. **Fields -** PROCEDURE CODE

241 - PREVAILING COST ERR - Claim in process. **STATUS -**O

242 - INPUT SPEND DOWN AMOUNT - Recipient liability to be verified from 110 - MNP. The recipient type case is 21 or 22 and the beginning date of service on the claim is the same as the begin date of eligibility (any segment). **Field -** RECIPIENT ID, STATEMENT COVERS PERIOD - FROM/THRU, INSURED'S ID, DATE(S) OF SERVICE.

243 - POT NOT ICF-I OR II - Place of treatment must be ICF-I or ICF-II. **STATUS -**D

244 - PROV RATE NOF - The provider file should have a valid date of service. From date submitted must be greater than or equal to effective date. Effective date on the file must be numeric and greater than 0.

245 - INVAL PROC TOS TRANS - The procedure performed must not conflict with the provider type, and/or procedure code, and/or type of claim. The procedure code must be Z9480, Z9481, Z9476, or Z9477. **Field -** PROCEDURE CODES, PROCEDURE CODE

246 - STAND BY NEC - Prolonged attendance billed. Pended for review.

247 - O.P. AUTH EXT NEED - Documentation must be present. Edit override code outpatient extension. **STATUS -**O

248 - DELETED, BILL CURR CD - Deleted. Bill current code.

249 - SURG REQ MED REV - Surgery requires review for attachments.

250 - DIA/PROC REQ REVIEW - Diagnosis/procedure requires review.

251 - DENY FOR DIAGNOSIS - If a procedure is not justified by a diagnosis, it is denied. **STATUS -**E

252 - DIAGNOSIS NOT ON FILE - STATUS -D

253 - DIAG DATE RESTRICTION - STATUS -O

254 - DIAG AGE RESTRICTION - When the diagnosis code and the recipient ID from the claim are compared to the diagnosis and the recipient file, the diagnosis code must be allowed for the recipient ID shown. **Fields -** RECIPIENT ID, PRIN CODE (primary diagnosis), INSURED'S ID NUMBER, DIAGNOSIS CODE, MEDICAL ASSISTANCE ID NUMBER, DIAGNOSIS PRIMARY AND DESCRIPTION, PRELIMINARY DIAGNOSIS.

255 - DIAG SEX RESTRICTION - When the diagnosis code and the recipient ID on the claim are compared to the diagnosis and the recipient file, the diagnosis code on the claim must be allowed for the recipient shown. **Fields -** RECIPIENT ID, PRIN CODE (primary diagnosis), INSURED'S ID NUMBER, DIAGNOSIS CODE, MEDICAL ASSISTANCE ID NUMBER, DIAGNOSIS PRIMARY AND DESCRIPTION, PRELIMINARY DIAGNOSIS

256 - DIAG PROC RESTRICT - The diagnosis on file must allow for the procedure entered for the claim. **Fields -** PRIN CODE (primary diagnosis), PROCEDURES ADN DATES, DIAGNOSIS CODE, PROCEDURE CODE, DIAGNOSIS PRIMARY AND DESCRIPTION, DISCHARGE OR CURRENT DIAGNOSIS, SERVICE CODE, PRELIMINARY DIAGNOSIS

257 - PAS - LOS 90TH EQ ZERO - The average length of stay for the procedure on the diagnosis file must not be zeros. **Field -** PRIN CODE (primary diagnosis)

258 - SPAN DATES/QUANT DIF - The quantity on the claim must be equal to the quantity calculated for the spanned days. **Fields -** DATE(S) OF SERVICE, DAYS OR UNITS.

259 - ANESTH REQ REVIEW - Anesthesia units/minutes require medical review.

260 - ANESTHESIA UNITS NOF - Anesthesia base units must be on file.

261 - INPUT M-CARE PD AMT - The quantity on the claim must be equal to the quantity calculated for the spanned days. **Fields -** TOTAL PROVIDER PAID AMOUNT

262 - ADJ-REQUIRES-REVIEW - Provider adjustment is on review. Works off indicator on provider file. **STATUS -**O

263 - PROCEDURE-AGE-RESTRT - Procedure is allowed only for recipient age 0 to 30 years.

264 - PA-01 REQUIRES REVIE - PA -01 form requires review for validity.

265 - SURG REQUIRES PA-O - Surgery done as IP requires valid PA-01 form. **STATUS -**E

266 - INVALID AMB SURG REV - Rev code must be valid for ambulatory surgery procedure. **STATUS -**D

267 - REQ-ICD9 - SURGICAL-CD - Revenue code 490 requires valid ICD9 surgical procedure.

268 - INVALID-TREATMENT-PL - Treatment place must be correct. **STATUS -**D

269 - ANES.CPT N/C-M'AID - ANES. CPT must be covered for Medicaid only. Bill Surg + Mod. **STATUS -**D

270 - CLAIM OVER 90 DAYS - Claim must not exceed 90 days filing limit (Pharmacy). **STATUS -**O

271 - CLAIM OVER 6 MONTHS - Claim must not exceed 6 month filing limit. **STATUS -**O

272 - CLAIM OVER 1 YEAR - Claim must not exceed 1 year filing limit. **STATUS -**D

273 - TPL/PRIVATE - The program searches to find out if recipient has more than one source of private insurance. **Field -** CARRIER CODE. **STATUS -**D

274 - POSSIBLE TPL - Possible third party liability. **STATUS -**O

275 - RECIP MEDICARE ELIG - The program searches to find out if recipient has Medicare coverage. **STATUS -**D

276 - HIGH VARIANCE ERROR - If claim type is 03(outpatient) and the amount billed is greater than calculated payment times 15 = high variance error;

If claim type is 04 (physician), the procedure is 80000 through 89999, the type of service is 05, and the amount billed divided by units of service is greater than 100 = high variance error. All other physician claims will generate high variance if the billed amount is greater than calculated payment times 15;

If claim type is 05 (rehabilitation services), 11 (adult dental), or 13 (EPSDT screening) and the amount billed is greater than calculated payment times three = high variance error;

If claim type is 06 (home health) and the amount billed is greater than calculated payment times five = high variance error;

If claim type is 07 (ambulance transportation) and the amount billed is greater than calculated payment times four = high variance error;

If claim type is 08 (non-ambulance transportation) and the amount billed is greater than calculated payment times four = high variance error;

If claim type is 10 (EPSDT dental) or 11 (adult dental), the procedure is other than D0240, D0230, or D9230, and the billed amount is greater than 400 percent of the calculated payment = high variance error;

If claim type is 12 (pharmacy) and the claim is not a facsimile (batch range 150-179), and the billed amount is greater than calculated payment times three = high variance error.

Fields - TOTAL CHARGES; CHARGES; USUAL AND CUSTOMARY FEE; RX PRICE

277 - LOW VARIANCE ERROR - If claim type is 12 (pharmacy) and the amount is less than calculated payment times .25 = low variance error;

If claim type is 10 (EPSDT dental), the procedure is other than D2129, D0230, or D9230 or the provider is other than 0088040 and the amount charged is less than calculated payment times .10 = low variance error;

If claim type is 04 (physician), the media is not 1 (tape to tape), and the amount charged is less than calculated payment times .10 = low variance error;

If the claim type is 06 (home health), 05 (rehabilitation services), or 11 (adult dental) and the amount charged is less than calculated payment times .10 = low variance error.

Fields - TOTAL CHARGES; CHARGES; USUAL AND CUSTOMARY FEE; RX PRICE

278 - RECIP ELIG MEDICARE - The recipient is possible eligible for Medicare. **STATUS -** O

279 - PROF COMP INVD POT - If the procedure modifier is 26, then the place of treatment must be 1, 2, or 3 (for professional components only). **Fields -** PLACE OF SERVICE

280 - MANUAL PRICE REQ - Manual pricing required. Hard copy of bill.

281 - VISIT INC. SURG CHGS - Office visit cons. billed separately from surgical fee. **STATUS -**E

282 - PRE-OP INC IN SURG - Pre-op included in total surgery fee. **STATUS -**E

283 - POST-OP INC IN SURG - Post -Op included in the total surgery fee. **STATUS -**E

284 - MANUAL PRICE GR BILL - Manual price exceeds billed charges.

285 - PAYMENT GR BILLED CH - The co-insurance and deductible payments should not be greater than the billed charges. **Fields -** BILLED CHARGES; CO-INSURANCE; TOTAL CHARGE; CO-INSURANCE DEDUCTIBLE

286 - BENDEX IND MEDICARE - Bendex code indicates that recipient is Medicare eligible. **STATUS** -O

287 - PAT LIB EXCEEDS CHG - Patient liability should not exceed billed charges. **STATUS -**E

288 - PROC/DESC CONFLICT - Procedure code and description should not be in conflict. **STATUS -**E

289 - INV DENY FOR PROV NO - When a provider number is found to be invalid, a deny should not be entered without correcting the provider number.

290 - TPL RESOURCE REQ EOB - An EOB must be attached for recipients with other resources **indicated. STATUS** -D

291 - FOUND MULT RESOURCES - The program found more than one TPL carrier on the TPL matrix file for the recipient. **Field -** PAYMENT SOURCE

292 - FOUND NO TPL AMOUNT - When a carrier code is entered, a TPL amount must also be entered on the claim. **Fields -** PAYMENT SOURCE

293 - RECYC RECI INELG DOS - Eligibility file must have a payable segment for date of service. **Fields -** RECIPIENT (MID) AND DATE OF SERVICE

294 - RECYC RECIP NOF - The recycled count is three and the recipient is still not on file.

295 - RECIP RECYCL 3 TIMES - Recipient is ineligible - recycled three times. **STATUS -**D

296 - CAR-CODE REQ REVIEW - The carrier code on the claim must match the code on the recipient's TPL matrix. **Fields -** PAYMENT SOURCE

297 - BANKRUPT. FILE W/CARR - Declared bankruptcy. The file is with the carrier for possible payments.

298 - INVALID PROC CODE - Procedure code for date of service must be valid.

299 - PROC/DRUG NOT COVERED - The procedure or drug not covered by Medicaid. **STATUS -**D

300 - CLAIM SPANS FISCAL YR - Claim from and Thru date must not overlap the fiscal year end date. **Fields -** STATEMENT COVER PERIOD - FROM/THRU

301 - ADMISN MUST BE EMER - If the hospital is registered on the provider file as Emergency Only, then the nature of the admission must be A for emergency. **Fields -** PRIN CODE (PRIMARY DIAGNOSIS)

302 - NO EMER 110-HE ATTACH - If provider type is 55 (emergency access hospital) claim will pend. **Fields -** ATTACHMENT

303 - CLAIM SPANS CY 1983 - Claim must not span calendar year 1983. **STATUS -**D

304 - INV BABY/MTHR ADMISN - The type of admission code must be equal to 4 when the diagnosis code indicates delivery. **Fields -** ADMISSION TYPE; ADMISSION SOURCE; PRIN CODE (PRIMARY DIAGNOSIS)

305 - INV BABY/MTHR PROC - Surgical procedure must be delivery. **Fields -** PROCEDURES AND DATES

306 - INV BABY ADMISSION - The date of service must not be greater than the recipient's date of birth by less than four. If so pend the claim, unless the type of admit is 4 and the source admit is 2, 3, or 4. **Fields -** ADMISSION TYPE; STATEMENT COVERS PERIODS - FROM/THRU

307 - SURG PROC MISSING - When there are cost center codes for surgery, a surgical procedure must be entered. **Fields -** PROCEDURES AND DATES

308 - SURG NAME/NO MISSING - When a surgical procedure is entered, an entry must be made in the physician name/number field. **Fields -** ATTENDING PHYSICIAN ID

309 - SURG DATE MISSING - Date of surgery must be specified as a valid date. **Fields -** PROCEDURES AND DATES

310 - SURG DTE LT SRV FROM - The date of surgery must be greater than or equal to the Service From Date. **Fields -** STATEMENT COVERS PERIOD - FROM/THRU; PROCEDURES AND DATES

311 - SURG DTE GT SRV THRU - The date of surgery must be less than or equal to the Service Thru Date. **Fields -** STATEMENT COVERS PERIOD - FROM./THRU; PROCEDURES AND DATES

312 - ACCOM DAYS LT 1 - At least one accommodation day must be indicated. **STATUS -**D

313 - AMB SURG DAYS NE 1 - The days of service cannot be greater than 1.

314 - PRIVATE ROOM PEND - If the accommodation room rate is for a private room, the hospital must be one indicated as "private room only." Otherwise the claim will pend for manual review. **Fields -** R CODE; REMARKS

315 - PROSTHESIS NOT PA - When Prior Authorization is required, it must be indicated on the claim.

316 - COV DAYS NE ACCOM - The accommodation days entered from this claim must equal the total calculated days. **Fields -** STATEMENT COVER PERIOD - FROM/THRU; COV D

317 - STMT DTE/ACCOM CONFL - The total accommodation days must not be greater than the dates of service range. If the revenue code is 170 through 172, 175, 179, 113, 123, 153, or 203, nursery days are calculated. All other accommodation days are mothers days. If mothers days are greater than zero, then mother days must be equal to covered days. If there are no mother days, then nursery days must be equal to covered days. **Fields -** STATEMENT COVERS PERIOD - FROM/THRU; COV D; R CODE; S-UNITS

318 - CHAMPS PRICING PEND - Children's Hospital - Pend for manual pricing. **STATUS -** O

319 - PSRO DAY/DTE MISSING - PSRO Hospital - days and dates must be present and valid. **STATUS -**O

320 - PSRO SIG MISSING - PSRO Hospital - Signature must be present. **STATUS -**O

321 - PSRO FROM LT ST FROM - PSRO From Date must be greater than the Statement From Date. **STATUS -**O

322 - PSRO THRU GT ST THRU - PSRO Thru Date must be less than the Statement Thru Date. **STATUS -**O

323 - PSRO DAY/DATE CON - PSRO dates must not conflict with PSRO days. **STATUS -**O

324 - PSRO DAYS NE ACCOM - PSRO dates must be present and must equal accommodation days. **STATUS -**O

325 - PAS-LOS DAYS MISSING - PAS-LOS days must be present on the diagnosis file. Fields - PRIN CODE (PRIMARY DIAGNOSIS)

326 - NO PER DIEM RATE - The Per Diem inpatient hospital rate must be on file for dates of service. **Fields -** STATEMENT COVERS PERIOD - FROM/THRU

327 - ADJ>ORIG COV'D DAYS - Adjusted covered days must not be greater than original covered days. **STATUS -**O

328 - PROV NOT CERTIFIED - Provider must be certified for service. **STATUS -**D

329 - CLIA NOT CERT DOS - CLIA number must cover date of service. **STATUS -**D

330 - QMB NOT MED. ELIG - QMB must be Medicaid eligible. **STATUS -**D

331 - ABORTION JUST - Must meet program criteria for abortion. **STATUS -**E

332 - STERILIZATION <21 - Sterilization is not covered for recipient under the age of 21. **STATUS -**D

333 - AUTH MINOR UNM MO - There must be documentation or an edit override code for minor, unmarried mother to use unborn identification number. Fields - RECIPIENT ID; INSURED'S ID NUMBER

334 - CONSENT 30/180 DAYS - Consent must be at least 30 but no more than 180 days. **STATUS -**D

335 - SERVICE LIMIT REVIEW - The number of services must not exceed the program limit and the claim must not have an attachment (media code 5). **Fields -** DESCRIPTION (PROCEDURE CODE), PROCEDURE CODE

336 - AB REQUIRES REVIEW - Abortion requires review.

337 - CONSENT FORM REVIEW - Sterilization OFS form 96 requires review.

338 - HYSTER REQ REVIEW - Acknowledgement requires review.

339 - OCCUR DATES CONFLICT - When occur codes are 22 (date active care ended) and 42 (date of discharge) the dates must be equal. **Fields -** OCCURRENCE CODES

340 - SPAN DAYS CONFLICT - The number of days represented by the From/Thru dates must equal non-covered days. **Fields -** NCD; OCCURRENCE SPAN

341 - DENY TO BE REBILLED - STATUS -E

342 - PSRO DATES MISSING - PSRO dates must be present. **STATUS** -O

343 - OFS FORM 146 MISSING - OFS Form 146 must be present. **STATUS** -D

344 - SPAN FROM THRU CONFL - When the occurrence span code is 74 (non-covered level of care) or 80 (leave of absence days), the span From and Thru dates must be valid. **Fields -** OCCURRENCE SPAN.

345 - INV ZERO BILLED DAYS - When days are zero, the patient status must be 9. **STATUS** -D

346 - INVALID WAIVED LOC - The entry in the waived level of care field must be a valid code. **Pend Reason -** INVALID-WAIVED-LOC

347 - EXCEEDS MAX-23 DAYS - Must not exceed maximum monthly days. **STATUS** -D

348 - S/C EXCDS 80% C-CARE - Service charge must not exceeds 80% of comparable care. **STATUS** -D

349 - INVALID TYPE CASE - Recipient must be covered for this service. **STATUS** -O

350 - LTC SNF/DTE ERR - LTC SNF Thru date must be correct. **STATUS** -O

351 - LTC MISSING CERT DTE - LTC Certification Date or Admit date must be present and valid. **STATUS** -O

352 - INV LTC CERT DATE - A certification date to admit this recipient to an LTC facility must be present. **Field -** CERTIFICATION DATE

353 - SRV DTE PRIOR CERTIF - Service date must not be prior to LTC certification date. **Fields -** CERTIFICATION DATE; FROM DOS

354 - SRV DTE LT PROV LIC - The service date must not be prior to provider licensing effective date. **STATUS** -O

355 - NO 51 NH - The program will search for long term care 212 adjustment with media code 5 (attachment) and a level of care change. **STATUS** -D

356 - TOT/LOC DAYS CONFL - To-Day / Tot -Days / Status must not conflict. **STATUS -**D

357 - LTC DAYS/ DATES CONFL - LTC level of care days must agree with the From and Thru dates for the level of care. **Fields -** FROM DOS; TO DAY; LEV 2; LEV 3

358 - INVLD RATE FOR LOC - A valid rate must be found for a long-term level of care. **Fields -** LVL OF CARE; LEV 2; LEV 3

359 - PREV MONTH BILLING - Billing should not be for month prior to bill month. **STATUS -**O

360 - PROC CERT DATE ERROR - Provider certification must not be expired as of date of service. **STATUS -**O

361 - RECIP EXCD HM/LV DYS - Recipient must not exceed the maximum number of home leave days (25). **STATUS -**O

362 - ICF-H HM LV DYS EXCD - Facility must not exceed the maximum recipient home leave days. **STATUS -**O

363 - OFS 24 NOT ON FILE - STATUS -O

364 - RECIP INELIG/DECEASE - STATUS -D

365 - ANESTH REP REQ - Anesthesiology report requested. **STATUS -**E

366 - SEND OP&PATH REPORT - Send both operative and pathology report. **STATUS -**E

367 - ADJ. DENY - Adjustment denied. Original claim paid correctly. **STATUS -**E

368 - HOME LEAVE EXCEED 14 - Recipient's home leave days must not exceed 14 days. **STATUS -**O

369 - PROV NOT AUTH EMC - Provider must be authorized for EMC **submission. STATUS -**D

370 - UNABLE TO CALCU COS - Claim in process. **STATUS -**O

371 - TIMELY FILING REVIEW - If the dates of service shown on the claim exceed the state's filing limitation, the claim(s) must be accompanied by appropriate documentation indicating a previous submittal. Appropriate documentation can be the Unisys Remittance Advice, the Unisys Return Letter, or the Unisys or BHSF correspondence referencing the specific claim. For Physician, Chiropractors, Independent labs, Dentists, Rehab Centers, Hemodialysis Centers, DME, Substance Abuse Clinics (private or public), Mental Health Clinic (private or public), Mobile Radiology, Pharmacy, Transportation, Long Term Care, and Adult Day Care the time limit is 12 months. **Exceptions:** (a) Claims for Medicare/Medicaid recipients

(crossovers), (b) Claims for services which there is other third party liability, (c) Claims for recipient with retroactive eligibility (spend-down), (d) Claims previously processed.

372 - INVALID LEAVE CODE - The leave code must be A or B.

373 - INVALID LEAVE DATE - When the status is 1, 2, 3, or 7, the total days and the absent day "to" field must not conflict.

374 - INSUFFICIENT DATA - Unable to process - Rebill - Attention P. Misner. **STATUS -**D

375 - PT STAT REQ HOSP LVE - If the patient status code is 1, there must be hospital leave days entered. **Fields -** STAT; COMMENTS SECTION OF TAD

376 - ADJ DAYS CONFL HIST - Adjustment days must not conflict with history days. **STATUS -**D

377 - PAYABLE QMB RECIP - Payable only for QMB recipients.

378 - MO MEDICARE PAID DATE - There must be a valid entry in the Medicare paid date field.

379 - HOME LEAVE DAY REDUC - Home leave days reduced to one/half per diem. **STATUS -**E

380 - AMBULANCE-REQ-ATTACH - Claim requires MD certification attached after 2/14/87. **STATUS -**D

381 - LTC-MED-LOA-OVER-10 - LTC leave days must not exceed limit - 10 per hospital stay. **STATUS -**E

382 - NO-ACTION-CODE-IND - Action code must be A-Add, C-Change, or D-Delete. **STATUS -**D

383 - SERV. IN MED SCREEN - Service included medical screening. **STATUS -**D

384 - NOT COVERED NH RESID - Not covered for nursing home resident.

385 - NOT COVERED NH RESID - Diabetic supplies not covered for LTC recipient.

386 - NOT PAY W/CLIA CERT - Not payable with CLIA cert type.

387 - CLIA# NOT ON FILE - CLIA number must be on file.

388 - RECIP NOT COVER, DRUG - Recipient must be covered for this drug.

389 - LOCK-IN RECIPIENT - Recipient is MD, Pharmacy restricted - Pharmacy invalid.

390 - SERV, MAX 1 PER MO - Service must not exceed maximum allowable of 1 per month.

391 - LTC LV DAYS OVER MAX - LTC hospital leave days should not be in excess of maximum of 5 - Budget cut.

392 - ICF-MR LV OVER MAX - ICF-MR leave should not be in excess of maximum 22/30 Budget cut.

393 - NF LV DAYS OVER MAX - NF Home leave days should not be in excess of maximum 4-Budget cut.

394 - REHAB CTR SRV NOT CO - Rehab Center services must be covered for nursing home resident.

395 - HOSP LEAVE DAYS>7 - Hospital leave days must not exceed 7.

396 - HOME LEAVE DAYS>15 - Home leave days must not exceed 15.

398 - BILL LOCAL/PRENAT LAB - Bill local assigned for prenatal panel.

399 - W/MULTCH.TEST PAN CD - Included in multichannel test panel codes.

400 - REFER PHYSICIAN REQD - Referring physician entry required in the referring physician field.

401 - CONCURRENT CARE - Concurrent care is not covered by the program. **STATUS -**E

402 - NO SERV EXCEEDS MAX - The number of services cannot exceed the maximum / cutback applied. **STATUS -**E

403 - MULTIPLE SURGERY - Pended for manual pricing.

404 - NON-EMER TRANS OUTPT - Non-emergency transportation should not be billed on outpatient form. **STATUS -**D

405 - OUTSIDE LAB NOT COVD - Outside laboratory services not covered. **STATUS -**D

406 - EXCEEDS 3 TREATMENTS - Three chiro treatments may not be received on the same day. **STATUS -**D

407 - NONEMER TRANS REQ PA - If the claim type is 08 (non-ambulance transportation), the type of service is 03 (non-emergency), and the PA date is not numeric (is alpha, spaces, or characters), then pend. **Fields -** PRIOR AUTHORIZATION DATE. **STATUS -**O

408 - NON-EMER MLS GR 400 - Non-emergency miles must not exceed 400. State authorization required. **STATUS -**D

409 - EMER MILES>25 - Emergency miles must not exceed 25. **STATUS -**O

410 - REHAB REQUIRES PA - Prior authorization s required for rehab services claim.

411 - 1 VISIT ALLOW PER DAY - Only one home health visit is allowed per day. Page 22 in the manual. **STATUS -**D

412 - PA AMT GR BILLED CHG - PA amount must not be greater than billed charges.

413 - DME REQUIRES PA - Prior authorization is required for DME.

414 - PA AMOUNT MISSING - Prior authorization amount must be present.

415 - PA AMOUNT GR LEVEL 3 - Prior authorization must not be greater than level 3 charge.

416 - TRNS NO HOSP BNFT. - Transportation must not be billed for outpatient hospital claim for a hospital not authorized with certified ambulance transportation. **Fields -** R CODE

417 - NON-PODIATRY SERVICE - When the provider type is a podiatrist, then the procedure code must be one that is allowable for this type of provider. **Fields -** PROVIDER NUMBER; PROCEDURE CODE

418 - DME PRICE REQ REVIEW - Eye anomalies review required for DME price. **STATUS -**O

419 - OFS REV PA DT GT DOS - OFS to review - PA date greater than service date. **STATUS -**E

420 - SPECIALTY RESTRICTED - When the provider type is 28, a procedure code equal to X0014 - X0015 must be entered for date of service prior to October 29, 1984.

421 - OFS REV INV PA DATE - OFS to review invalid PA date /signature. **STATUS -**E

422 - ONE H. HLTH NURSE/DAY - Only one Home Health nurse visit is allowed per day.

423 - ONE H. HLTH AIDE/DAY - Only one Home Health aide visit is allowed per day.

424 - ONE H. HLTH PT/DAY - Only one Home Health PT visit is allowed per day.

425 - ONE DOT PER RECIP/DY - Only one DOT per recipient allowed per day.

426 - BILL HR CD PRE 15MIN - Bill CM hour code before 15 minute code.

427 - PSYCH SERV NOT COVER - Psychiatric services not covered under Home Health.

428 - ADMIN. PEND - Administrative pend.

429 - NOT PAY FOR MED NEED - Not payable for medically needy program.

430 - MOD NOT NEEDED - RESUB - Modifier not needed, remove and resubmit.

432 - QTY>PACKAGE SIZE - Quantity should not exceed package size.

433 - MISSING/INVALID DIAG - Diagnosis code must be present and valid. **Fields -** DIAGNOSIS, SECONDARY DIAGNOSIS **Pend Reason -** NO-DIAGNOSIS-FOUND

434 - BILL MEDICARE NEB MED - Bill Medicare nebulizer med.

435 - MED INDIC NOT PAYABL - Medical indication not payable.

436 - DAYS SUPPLY OVER MAX - Days supply should not exceed program maximum of 100.

437 - QTY OF 1 - 1 VIAL - If drug is in a vial, quantity of 1 = 1 vial

438 - MFTR SAYS NDC OBSOLETE - Manufacturer notified us that NDC is obsolete.

439 - MFT SAYS FOOD SUPPLM - Manufacturer has identified product as food supplement.

440 - ELIG TERM-CARD INVAL - If the eligibility category has been terminated, then the card is invalid.

441 - 2A, 2B-RX NOT FILLED - Outcome 2A or 2B - RX not filled - Transaction reporting.

442 - DRUG/DRUG INTERACT - Drug/Drug interaction.

443 - THERAPEUTIC OVERLAY -

444 - ADD ERROR 444 - This is an attempt to add error 444. **STATUS -**T

445 - DUP DRUG THERAPY - Duplicate drug therapy.

446 - PREGNANCY PRECAUTION -

447 - MON. EARLY/LATE REFIL - Compliance monitoring. Early or late refill.

448 - GIVE DATE FOR TRANSP - Transplant discharge date or other DX needed.

449 - BILL MEDICARE FIRST - Bill Medicare first based on discharge date.

450 - NO-MATCH PRESCRIBER - Non-matched prescriber identification number. **STATUS -**O

451 - PRESCRIBING DENTAL AGE ERROR - Prescribing provider dental-recipient ages must not be greater than 21. **Fields -** PROVIDER NUMBER

452 - SCH2 NARC NO REFILL - Schedule 2 narcotic cannot be refilled. The refill indicator can only be 0. **Fields -** NAT'L DRUG CODE; DRUG NAME; REFILL CODE

453 - SCH2 NARC OVER 5 DAY - There cannot be more than one day between the prescription date and the RX date. **Fields -** RX DATE; DATE RX FILLED; DRUG NAME

454 - NEW PRESC OVER 6 MOS - No more than 10 days can elapse from prescription date to the RX date. **Fields -** RX DATE; DATE RX FILLED

455 - REFILL OVER 6 MONTHS - When there is a valid refill code, no more than 186 days can have elapsed since the prescription date. **Fields -** RX DATE; DATE RX FILLED

456 - DRUG NOT MAC - MAC override block should only be filled if drug is MAC. **Fields -** QUANTITY; RX PRICE

457 - QTY OVER PROGRAM MAX - The quantity and/or days supply cannot exceed the program maximum allowed.

458 - MAC/FUL COST IS ZERO- The MAC cost must be found on the procedure/formulary file for this drug and for the date(s) of service shown. **Fields -** NAT'L DRUG CODE

459 - PENDING FOR FILE REV - This drug on the drug file has not been activated (set to pay or deny).

460 - NDC OBSOLETE - NDC probably obsolete - check label/computer.

461 - REFILLS NOT PAYABLE -STATUS -D

462 - HCFA: NDC OBSOLETE - HCFA notified us that NDC is obsolete.

463 - MAC OVERRIDE NOT NEE - Drug does not need MAC override.

464 - DRUG IS KIT/VERF.QTY - Drug unit of measurement is a kit. Please verify quantity.

465 - INVALID NDC - Not on HCFA file.

466 - HRD COPY REQ- FERTILI - Hard copy required for fertility preparation.

467 - COV MDCARE IF INSULI - Item covered by Medicare id recipient is insulin treated.

468 - JUSTIFY EYEGLASSES - Documentation is required for more than 3 pairs of eyeglasses per year.

469 - GLASSES DENIED - No documents to justify more than 3 pairs of glasses per year.

470 - ANES AND MED DOC REQ - Attach anesthesia record and document medical necessity.

472 - MFCTR NOT IN REBATE - Manufacturer should have entered into HCFA rebate agreement.

477 - JUSTIFY OVER 1/A/YR - Documentation must be sent to justify over one procedure per year.

480 - DEDUCT EXCEEDS MAX - Deductible amount applied by the provider must not be greater than the deductible required by Medicare.

490 - UTILIZE HMO - Must utilize HMO services.

492 - HMO REVIEW - HMO EOB requires review.

499 - JUSTIFY PATH CONSULT - Documentation must be sent to justify path consult.

500 - USE 62/66 MOD, RESUB - Use of 62/66 Mod indicated by report. Resubmit accordingly.

501 - EXACT DUPE 16 TO 01 - Exact duplicate error: Adult day care and hospital. **STATUS -** O

502 - EXACT DUPE 16 TO 02 -Exact duplicate error: Adult day care and LTC. **STATUS -**O

503 - EXACT DUPE 16 TO 16 - Exact dupe: Identical adult day care claims. **STATUS -**D

504 - EXACT DUPE 17 TO 01 - Exact dupe: Habilitation and hospital. **STATUS -**O

505 - EXACT DUPE 17 TO 02 - Exact dupe: Habilitation and LTC. **STATUS -**O

506 - EXACT DUPE 17 TO 17 - Exact dupe: Identical LHA claims. **STATUS -**D

507 - EXACT DUPE 18 TO 01 - Exact dupe: Homemakers and hospital. **STATUS -**O

508 - EXACT DUPE 18 TO 02 - Exact dupe: Homemakers and LTC. **STATUS -**O

509 - EXACT DUPE 18 TO 18 - Exact dupe: Identical Homemakers claims. **STATUS -**D

551 - SUSPCT DUPE 16 TO 01 - Suspected dupe: Adult day care and hospitals. **STATUS -**O

552 - SUSPCT DUPE 16 TO 02 - There is a paid claim for this recipient with overlapping dates of service. **Fields -** RECIPIENT ID, PROVIDER ID, DATES OF SERVICE

553 - SUSPCT DUPE 16 TO 16 - There is a paid claim for this recipient with overlapping dates of service. **Fields -** RECIPIENT ID, PROVIDER ID, DATES OF SERVICE

554 - SUSPCT DUPE 17 TO 01 - Suspected dupe: Habilitation and hospitals. **STATUS -**O

555 - SUSPCT DUPE 17 TO 02 - Suspected dupe: Habilitation and LTC. **STATUS -**O

556 - SUSPCT DUPE 17 TO 17 - Suspected dupe: Identical habilitation claims. **STATUS -**O

557 - SUSPCT DUPE 18 TO 01 - Suspected dupe: Homemakers and hospitals. **STATUS -**O

558 - SUSPCT DUPE 18 TO 02 - Suspected dupe: Homemakers and LTC. **STATUS -**O

559 - SUSPCT DUPE 18 TO 18 - Suspected duplicate. Identical homemakers claims. **STATUS -**O

600 - 10 MO PAST PA DATE - Claim must be filed within 10 months of prior authorization. **STATUS -**O

601 - ADULT DENTAL - UNDER21 - An adult dental claim form cannot be used for someone under the age of 21. **Fields -** MEDICAL ASSISTANCE ID NUMBER

602 - SURFACE CODE CONF - Number of surface specified must be less than or equal to the number of actual performance. **Fields -** TOOTH NUMBER OR LETTER; SURFACE; PROCEDURE CODE

603 - TOOTH CODE REQUIRED - The program has compared the procedure code to the procedure/formulary file and found that a tooth code is required for the procedure used on the claim. **Fields -** TOOTH NUMBER OR LETTER; SURFACE

604 - EPSDT DENT AGE GR 21 - An adult dental claim must be used for recipient over age 21. **Fields -** MEDICAL ASSISTANCE ID NUMBER

605 - CATEG B SERV REQ PA - When the category is B dental service, there must be prior authorization. **Fields -** AGENCY AUTHORIZATION DATE/SIGNATURE

606 - ADULT DENTAL REQ PA - Prior authorization date must be present . **Fields -** AGENCY AUTHORIZATION SIGNATURE/DATE

607 - PA DATE GR SERV DATE - The prior authorization date must not be greater than service date. **Fields -** PRIOR AUTHORIZATION DATE; DATE SERVICE PERFORMED

608 - SEAL. NOT PAY. TOOTH - Sealant must be payable for the tooth.

609 - RESTOR NOT ALLOW-AGE - Restoration must be allowable for a particular age.

610 - PULP CAP NO PAY DECI - Pulp cap must be payable for decidous tooth.

611 - PULPOTOMY NO PAY-PER - Pulpotomy not payable for permanent tooth.

612 - PIN NOT PAY THIS TOO - PIN not payable for this tooth.

613 - INVALID/MISSING CODE - Tooth code must be present and valid.

614 - HEMA.COMP/IND/BILLED - Hematology component/indice/profile must be billed correctly.

615 - 1 PRENAT PAN PAY SAM - Only one prenatal panel is payable on the same day of service.

616 - ONE PANEL/PREGNANCY - Only one prenatal lab panel allowed per pregnancy.

617 - LAB, COMPON NOT PAYAB - Prenatal lab panel and component not payable

618 - URINALYSIS NOT BILLE - Urinalysis must be billed correctly.

619 - PAN & IND CODE/PANE - Billed panel and individual code within panel.

620 - PAN &IND CODE/PANE - One urinalysis per pregnancy is payable.

621 - NEED OP/PATH/HISTORY - Resubmit with operative and path. reports and history.

622 - EXACT DUPE 01 TO 03 - Outpatient and inpatient hospital service performed on the same day.

623 - EXCEEDS ONE PER YEAR - Send documentation to justify more than one per year.

624 - THIS SERV NOT PAYABL - This chiropractic service no longer payable.

625 - MED NEC INSUFFICIENT - Documentation of medical necessity must be sufficient.

626 - SEND EPSDT REFERRAL - EPSDT referral and proof of medical necessity must be sent.

627 - SEND MED NECESSITY - Proof of medical necessity and EPSDT referral must be sent.

628 - NEED EPSDT &MED NEC - EPSDT referral and proof of medical necessity needed.

629 - ASSIGNED MEDICARE_IN - Assigned Medicare must be correct.

630 - SCREENING INCOMPLETE - Screening must be complete. **STATUS -**O

631 - EPSDT AGE ERROR - EPSDT age must not be over 21 years of age. **STATUS** -D

632 - ADJUST UB82 MISMATCH - Adjustment UB82 indicator must match. **STATUS** -D

633 - VOID COMPN, REBILL - Void components and rebill panel code.

634 - VOID REBILL HIGH COD - Void paid code and rebill higher code in triad.

635 - HIGH CODE TRIAD PAID - Higher code in triad already paid.

636 - REBILL VISIT CODE - Critical care not documented. Rebill appropriate visit.

638 - ONLY LO-LEVEL OFFICE - Only low-level office visit allowed.

639 - RECIP MAX SER/FISCAL - Recipient should not exceed medical service for the fiscal year.

640 - EXCEEDS MAX, PHYS, YRS - Must not exceed maximum allowed by same physician within 3 years.

641 - EXCEEDS MAX/HOSPITAL - Must not exceed maximum allowed per hospitalization.

642 - 1 CONSULT/PHYS/HOSP - Only 1 initial consultation from the same physician per hospitalization.

643 - EXCEEDS DAY MAX VISI - Must not exceed daily maximum allowed visits.

644 - VISIT CODE PD/DOS - Visit code must not already be paid for this date of service.

645 - VISIT/DISCHG NOT ALL - Visit/discharge not allowed on same day by the same physician.

646 - EXCEEDS DAY MAX VISI - Must not exceed daily maximum visits per provider or specialty.

647 - SURG. HOSP VIS NO PAY - Surgery and hospital visit by the same physician not payable.

648 - DOC REQ CONCUR CARE - Resubmit with documentation substantiating concurrent care.

649 - CUTBACK - VFC ADMIN PD - Cutback - VFC administration paid.

650 - PAY RED TO STATE MAX - Payment made at state maximum. **STATUS** -E

651 - HOSP CUTBACK APPLIED - Hospital cutback applied. **STATUS** -E

652 - SCH2 NARC NO REFILL - Schedule 2 narcotic cannot be refilled. **STATUS -**O

653 - SCH2 NARC OVER 24 HR - Schedule 2 narcotic must be filled within 24 hours. **STATUS -**O

654 - NEW PRESC OVER 10 DA - New prescription must be filled within 10 days. **STATUS -**O

655 - REFILL OVER 6 MONTHS - Refill must be filled within 6 months. **STATUS -**O

656 - OVER MAX DURATION - Must not exceed maximum duration of therapy. **STATUS -** O

657 - QTY OVER PROGRAM MAX - Quantity must not exceed program maximum. **STATUS -**O

658 - UNABLE TO PRICE CLAIM - Procedure code and description must not conflict. Unable to price claim. **STATUS -**E

659 - NO FED MATCH - REC - DOS - Must be a federal match for recipient on this service date. **STATUS -**E

660 - PAY RED TO LMAC MAX - Payment reduced to LMAC maximum. **STATUS -**E

661 - MEDICARE - COVERAGE - Claim voided or adjusted by state. Recipient has Medicare coverage. **STATUS -**E

662 - PAY REDUCED BY COPAY - Payment reduced by co-payment.

663 - NO ABORTION DONE - Abortion not performed. Fetus not alive at time of procedure.

664 - 1 PAYABLE /180 DAYS - Only one payable per 180 days.

665 - RESUB HRDCPY ADJ/VOI - Medicare adjustment/void. Resubmit hardcopy adjustment or void claim.

666 - NO OF RX GR THAN 5 - Number of prescription must not be greater than 5.

667 - RX>5, MED NEC, DX REQU - Number of prescription is greater than 5 due to medical necessity. DX required.

668 - NO HIST. INSULIN REQ. - No patient history of insulin requirements.

669 - USE CODE W3340 - Rebill using code W3340 with appropriate modifier.

680 - ABORT PD MOTHER LIFE - Abortion paid. Mother's life endangered.

681 - BLK 82/83 SRGN NAME - Surgeon's name must appear in block 82 or 83 on UB92.

682 -96A INCOMPLETE/INCOR - 96A incomplete or incorrect.

683 - 96A DATED AFTER HYST - 96A dated after hyst. Resubmitted with emergency documentation.

684 - NEED EDC ON FORM 96 - EDC needed on 96. Signature must not be less than 30 days from tubal.

685 - NEED SPECIFIC REPORT - Resubmit with specific related report.

686 - ADMIT HIST, PHY, DISCH - Resubmit with admit history, physical, discharge summary.

687 - USE 52 REDUCE SERVIC - Resubmit with 52 modifier for reduced services.

690 - PAYMENT IN SURG FEE - Payment included in surgery fee.

691 - REBILL SURGERY - Visit paid in GSP. Void visit and rebill surgery.

692 - SEND TEST AND RESULT - Visual field test and results needed for review.

693 - ADJUST PAID LINE - Only a paid line, the correct paid line, can be adjusted.

694 - DID NOT SUB REQ DOC - Requested documents must be submitted. See previous RA.

696 - PROBLEM CODE PD 2YRS - Problem oriented code paid within 2 years.

697 - REQ OVERRIDE > 3650 - Request override for elderly WVR PCA units over 3650.

698 - CUTBACK-SERV 1 YEAR - Cutback, repair must yield denture serviceable for 1 year.

699 - REPR DENIED 1 YEAR - Repaid denied for 1 year post insertion.

700 - INCLUD TOTAL OB CARE - Included fee for total OB care. **STATUS -**D

701 - FOLLOW UP VS CHG - Consult follow-up visits not allowed. **STATUS -**E

702 - NEW PT/EST PT CD CON - New patient code and established patient code must not conflict. **STATUS -**D

703 - SEPARATE CHGS. EPIS - Episiotomy included in delivery charge. **STATUS -**O

704 - ER VISIT/INP HOS SER - Emergency room visit on date of inpatient hospital services. **STATUS -**D

705 - AID/RN/PT NO SAME DAY - Aide/RN/PT visit must not be on the same day as home health. **STATUS -**D

706 - SEPARATE NB CARE CHG - Follow-up NB care billed separately.

707 - SEPARATE CBC COMPS. - CBC components billed. To be combined to panel. **STATUS -**D

708 - SEP. CHG. FETAL MONIT - Fetal monitoring included in delivery fee. **STATUS -**O

709 - STERIL CONSENT - Sterilization consent form must be correct and eligible. **STATUS -** E

710 - UNILATERAL SAME DAY - Two unilateral procedures must not be on the same day/recipient/provider. **STATUS -**O

711 - 2ND RELINE SAME YR. - There must not be charges for 2nd. reline within same year. **Fields -** PROCEDURE CODE.

712 - 1 CATRCT LENS/SURG - The service limit file must not show one of the listed codes for this recipient.

713 - MULTI-CHANN TEST SEP - Panel automated multichannel test. **STATUS -**D

714 - MULTI-URINE TEST - Multi-urine tests billed. To be combined to panel. **STATUS -**D

715 - 2ND VISIT SAME DAY - There must not be a duplicate visit on the same day for the same recipient.

716 - PROC INCLUDED IN OV - Procedure included in the physician visit. **STATUS -**D

717 - FOUND TWO PANEL CODE - One panel a day is allowed. Billing provider. **STATUS -**D

718 - CODE INC FRAMES/LENS - CD 00089 included frame and lens. History indicated comp. payment. **STATUS -**D

719 - EMERG - COMB - XRAY - ONLY - Emergency can be combined with X-ray only. **STATUS -**D

720 - TO BE BILLED BY PROV - Must be billed by provider of service. **STATUS -**D

721 - SUR ASST NOT NEEDED - Procedure does not warrant surgical assistance. **STATUS -**E

722 - BILL EMERG OV/XRAY - Emergency cannot be combined with codes other than X-ray. **STATUS -**D

723 - 09340/09110 ONE FEE - Emergency visit and pallitative treatment must not be combined charges. **STATUS -**D

724 - EXCEEDS MAX DOLLAR - Must not exceed maximum dollar amount per tooth.

725 - D&C/BIOP-CERVIX CRG - See CPT-code 57520 includes D&C. Do not bill code 58120. **STATUS -**D

726 - MULTIPLE SURGERY - Multiple surgery pended for review.

727 - EXCEEDS DAILY MAX - Must not exceed daily service maximum. **STATUS -**E

728 - BLOOD COMP + PANEL - Blood component must not be billed along with panel code. **STATUS -**D

729 - URINE COMP + PANEL - Urine component must not be billed along with panel code. **STATUS -**D

730 - 1 INP HSP VST PER DA - Only one inpatient hospital initial or subsequent care visit allowed per day. **STATUS -**D

731 - ONLY ICD9 PROC ALLOW - Only ICD-9CM volume3 procedure allowed UB82. **STATUS -**E

732 - ATTACH DETAIL. DESCR. - Detailed description of procedure must be attached. **STATUS -**E

733 - 95165 - 90 DAYS - STATUS -D

734 - EXCEEDS-MAX-UNITS-AL - Recipient must not exceed maximum allowed services per 6 months. **STATUS -**O

735 - PREV PD ANES-SAME RE - Previously paid anes. or supervising anes, same recipient and date of service. **STATUS -**D

736 - ATTACH DET. DESCR DX - Detailed description of diagnosis must be attached. **STATUS -**D

737 - FEE IN SCREEN. FEE - Fee included in screening fee. **STATUS -**D

738 - ONLY ONE DO111/12 MO - Only one procedure code DO111 allowed in a 12 months period. **STATUS -**D

739 - EXCEEDS -MAX-UNITS-AL - Recipient must not exceed maximum allowed services per year. **STATUS -**D

740 - 1 - INTRAOCULAR -LEN- AL - Only one procedure V2630, V2631, V2632 allowed per recipient. **STATUS -**D

741 - ALLOW 1 00120, 00272 - Only one 00120, 00272, 01203 allowed per recipient during the same year or per provider per year.

742 - ALLOW 2 PER 5 YEARS - Only 2 of these procedures allowed in a 5 year period per recipient/provider.

743 - 2/PREG. EXCEEDED - Must not exceed the maximum of 2 pregnancies.

744 - 13/PREG-158A NEEDED - 13 allowed per pregnancy. 158-A needed for extension.

745 - 1/PREG - 158A NEEDED - Only one allowed per pregnancy. 158-A needed for unusual situations.

746 - 92065 ONLY 2X/WEEK - Procedure 92065 payable for only 2 times per week. **STATUS -**D

747 - PROVIDE SPEC RADIONU - Resubmit with specific nuclide/ amount used per PT/AMT PD/INVOICE.

748 - 1 DEL. ALLOW. 6 MTH SP - Only one delivery allowed in 6 month span. **STATUS -**D

749 - DELIVER/HYST CONFLIC - Delivery must not be billed after hysterectomy was done. **STATUS -**D

750 - STERILIZATION INDIC. - Found procedure 2 time. Indicates sterilization. **STATUS -** E

751 - HYST REQ ACK - Hysterectomy requires acknowledgment or proof previously sterile. **STATUS -**D

752 - TL NEEDS OFS 96 - Sterilization requires OFS Form 96. **STATUS -**D

753 - REBILL - DELIVERY - Rebill delivery (delivery-surgery) code and office visit. **STATUS -**D

754 - RVW READMIT/DSCHG DX - Pend for review of readmit or discharge diagnosis. **STATUS -**P

755 - BILL AS ADJ/CNT STAY - This should be billed as adjustment for CNT stay. **STATUS -**D

756 - DOC/READMIT SAME DAY - Resubmit with documentation of discharge and readmit on the same day.

757 - ADJUST PAID LINE/51 - Multi-surgery. Adjustment paid line with 51 modifier. Resubmit major. **STATUS** -D

758 - FND DUP SERV SM DAY - Must not have duplicate service on the same day.

759 - 2ND INTAKE-365 DAYS - Must not have second intake in 365 days without a preceding risk assess.

760 - AIR TRNSPT REQS P/A - State approval is required for air transportation. **STATUS** -E

761 - SEND DATED OP REPORT - Dated operative report must be sent for date billed.

762 - SEND DATED NOTES - Specific dated notes must be sent for each date billed.

763 - CORRECT OFS 96 SEC 1 - OFS 96 correctable error in section1.

764 - CORRECT OFS 96 SEC 2 - OFS 96 correctible error in section 2.

765 - CORRECT OFS 96 SEC 3 - OFS 96 correctible error in section3.

766 - CORRECT OFS 96 SEC 4 - OFS 96 correctible error in section 4.

767 - OFS96 NONCORRECTIBLE - OFS 96 error in 7, 8, 10, 11, 14, 15. Do not resubmit.

768 -RESUB/CORRECT MOD - No documentation for 62/66. Correct errors and resubmit.

769 - REFERRED TO P.A. - Do not resubmit. Claim to be reviewed by Prior Authorization.

770 - PERTINENT HIST/REQ - Resubmit with pertinent history.

771 - SEND L&D RECORDS - Resubmit with Labor and Delivery records.

772 - JUSTIFY/#UNITS - Notes justifying number of units billed must be sent.

773 - IN TRANSPLANT FEE - Included in global fee for transplant.

774 - INC IN RELATED PROC - Included in a related procedure.

775 - PAY CUT TOOTH/SURFAC - Payment cutback. Same tooth - same surface.

776 - ONGOING CM PRIOR TO - Ongoing CM prior to initial CM.

777 - ABORTION RAPE - PAID - Abortions due to rape paid.

778 - UNDERLINE UNLISTED - Attach procedure description (Underline in report).

779 - PROC. EXTRACT NOT PAY - Procedure on extracted tooth not payable.

780 - REBILL CORRECT UNITS - Units available for code. Rebill using units.

781 - MODIFIER NOT CORRECT - Inappropriate procedure code modifier. Rebill.

782 - OVER 3 SONO/PREG, 240 - must not exceed 3 sonograms per pregnancy 240 days.

783 - SEND DOC, ADD SONOGRA - Additional documents must be sent to justify.

784 - EXCEEDS MO LIMIT - Must not exceed monthly limit.

785 - SERV REV/CHIRO CNSLT - Service limit review by chiropractic consultant.

786 - UNKNOWN ABBREVIATION - Resubmit with abbreviation legend.

787 - SEND ALL DOCUMENTS - Documentation inadequate. See Feb. 94 and Aug.. 93 updates.

788 - DAILY NOTES NEEDED - Daily treatment and progress noted needed.

789 - ABORTION INCEST - PAID - Abortion due to incest paid.

790 - DO NOT SUBMIT - If service not justified by documentation, do not submit.

791 - SEND ALL DOCUMENTS - Over 25 encounters. See March and April 94 and August 93 updates.

792 - SAME DAY FAM NO PAY - Same day family care ind. liv not payable.

793 - PCA SERV LIMIT EXCEE - PCA service limit must not be exceeded.

794 - RESPITE SERV LIMIT - Must not exceed respite service limit.

795 - HCPC SPEC RESTRICTED - HCPC specialty restricted. Give attending physician number.

796 - ORIG/ADJ PROV DIFF - Original and adjusted billing provider number must not be different. **STATUS -**D

797 - DUP. ADJ. RECORD - Duplicate adjustment records entered. **STATUS -**D

798 - HIST ALREADY ADJUSTED - History record is already adjusted. **STATUS -**D

799 - NO ADJ HISTORY - No history record in file for this adjustment. **STATUS -**D

800 - ON-LINE DUPE DENY - Duplicate of previously paid claim. **STATUS -**D

801 - EXACT DUPE 01 TO 01 - Exact duplicate error - Identical hospital claims. **STATUS -** D

802 - EXACT DUPE 01 TO 14 - Exact duplicate error - Hospital and Title 18 - Institution. **STATUS -**D

803 - EXACT DUPE 02 TO 02 - Exact duplicate error - Identical LTC claims. **STATUS -**D

804 - EXACT DUPE 02 - 14 - Exact duplicate error - LTC and Title 18 - Institutional. **STATUS -**D

805 - EXACT DUPE 03 - 03 - Exact duplicate error - Identical Outpatient claims. **STATUS -**D

806 - EXACT DUPE 03 - 05 - Exact duplicate error - Outpatient and rehab services. **STATUS -**D

807 - EXACT DUPE 03 TO 06 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same. **Fields -** RECIPIENT ID, ATTENDING PHYSICIAN ID, STATEMENT COVER PERIOD - FROM/THRU, DESCRIPTION, TOTAL CHARGES, MEDICAL ASSISTANCE ID NUMBER, PROVIDER NUMBER, DATE OF EACH SERVICE, PROCEDURE CODE

808 - EXACT DUPE 03 TO 07 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

809 - EXACT DUPE 03 TO 08 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

810 - EXACT DUPE 03 TO 09 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

811 - EXACT DUPE 03 TO 13 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

812 - EXACT DUPE 03 TO 15 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

813 - EXACT DUPE 04 TO 04 - Exact duplicate error - identical physician claims. **STATUS -** D

814 - EXACT DUPE 04 TO 15 - Exact duplicate error - Physician and Title 18. **STATUS -**D

815 - EXACT DUPE 05 TO 05 - Exact duplicate error - Identical rehab - services claims. **STATUS -**D

816 - EXACT DUPE 05 TO 06 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, PROVIDER NUMBER, DATE OF EACH SERVICE, PROCEDURE CODE, CHARGE, MEDICAL ASSISTANCE ID NUMBER, SERVICE CODE,

817 - EXACT DUPE 05 TO 07 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, PROVIDER NUMBER, DATEOF EACH SERVICE, PROCEDURE CODE, CHARGE, MEDICAL ASSISTANCE NUMBER

818 - EXACT DUPE 05 TO 08 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, PROVIDER NUMBER, DATE OF EACH SERVICE, PROCEDURE CODE, CHARGE, MEDICAL ASSISTANCE NUMBER

819 - EXACT DUPE 05 TO 09 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, PROVIDER NUMBER, DATE OF EACH SERVICE, PROCEDURE CODE, CHARGE, MEDICAL ASSISTANCE NUMBER

820 - EXACT DUPE 05 TO 13 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, PROVIDER NUMBER, DATE OF EACH SERVICE, PROCEDURE CODE, CHARGE, MEDICAL ASSISTANCE NUMBER, SCREENING CODES, DATE OF CURRENT SCREENING

821 - EXACT DUPE 05 - 14 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same. **Fields -** PROVIDER NUMBER, MEDICAL ASSISTANCE NUMBER, SCREENING CODE, DATE OF CURRENT SCREENING, TOTAL CHARGE, RECIPIENT ID, ATTENDING PHYSICIAN ID, STATEMENT COVERS PERIOD - FROM/THRU, DESCRIPTION (PROCEDURE CODE)

822 - EXACT DUPE 06 TO 06 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same. **STATUS -**D

823 - EXACT DUPE 06 TO 07 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

824 - EXACT DUPE 06 TO 08 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

825 - EXACT DUPE 06 TO 09 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

826 - EXACT DUPE 06 TO 13 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

827 - EXACT DUPE 06 - 14 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

828 - EXACT DUPE 07 TO 07 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same. **STATUS -**D

829 - EXACT DUPE 07 TO 08 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

830 - EXACT DUPE 07 TO 09 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

831 - EXACT DUPE 07 TO 13 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

832 - EXACT DUPE 07 TO 15 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, PROVIDER NUMBER, DATE OF EACH SERVICE, PROCEDURE CODE, TOTAL CHARGES, INSURED'S ID NUMBER, CHARGES

833 - EXACT DUPE 08 TO 08 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same. **STATUS -**D

834 - EXACT DUPE 08 TO 09 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

835 - EXACT DUPE 08 TO 13 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, PROVIDER NUMBER, DATE OF SERVICE, PROCEDURE CODE, TOTAL CHARGES, DATE OF CURRENT SCREENING

836 - EXACT DUPE 08 TO 15 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same. **Fields -** MEDICAL ASSISTANCE NUMBER, PROVIDER NUMBER, DATE OF SERVICE, PROCEDURE CODE, TOTAL CHARGE, INSURED'S ID NUMBER

837 - EXACT DUPE 09 TO 09 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

838 - EXACT DUPE 09 TO 13 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

839 - EXACT DUPE 09 TO 15 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same. **Fields -** INSURED'S ID NUMBER, PROVIDER NUMBER, DATES OF SERVICE, PROCEDURE CODE, CHARGES

840 - EXACT DUPE 10 TO 10 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

841 - EXACT DUPE 10 TO 11 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same.

842 - EXACT DUPE 11 TO 11 - Dates of service must not overlap and provider ID, billed amount, type of service, procedure code, and procedure modifier must not be the same. **STATUS -**D

843 - EXACT DUPE 12 TO 12 - Exact duplicate error - Identical pharmacy claims. **STATUS -** D

844 - EXACT DUPE 13 TO 13 - Exact duplicate error - Identical EPSDT claims. **STATUS -**D

845 - EXACT DUPE 13 TO 15 - The dates of service must be equal and the procedure code /NDC must be the same drug. **Fields -** PROVIDER NUMBER, MEDICAL ASSISTANCE ID NUMBER, DATE OF CURRENT SCREENING, TOTAL CHARGES, INSURED'S ID NUMBER, PROCEDURE CODE, PROCEDURE MODIFIER, CHARGES

846 - EXACT DUPE 14 TO 14 - Exact duplicate error - Identical Title 18 claims. **STATUS -**D

847 - EXAT DUPE 15 TO 15 - Exact duplicate error - Identical Title 18 Professional claims. **STATUS -**D

848 - EXACT DUPE 12 TO 15 - The dates of service must be equal and the procedure code /NDC are for the same drug. **Fields -** DATES OF SERVICE, NAT'L DRUG CODE, PROCEDURE CODE.

849 - PD SAME ATTEN/DIF BL - Already paid same attending. Different billing provider.

850 - UNSPECIF SUSPCT DUPE - Suspected duplicate of previously processed claim. **STATUS -**O

851 - SUSPT DUPE 01 TO 01 - Provider type must not be the same and dates of service should not overlap. **Fields -** RECIPIENT ID, STATEMENT COVERS PERIOD - FROM/THRU, EST AMOUNT DUE.

852 - SUSPCT DUPE 01 TO 14 - Provider type must not be the same and dates of service should not overlap. **Fields -** RECIPIENT ID, STATEMENT COVERS PERIOD - FROM/THRU

853 - SUSPCT DUPE 02 TO 02 - Claim type must not be the same and dates of service should not overlap. **Fields -** RECIPIENT ID

854 - SUSPCT DUPE 02 TO 14 - Suspected duplicate error - LTC and Title 18 - Institutional. **STATUS -**O

855 - SUSPCT DUPE 03 TO 03 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** RECIPIENT ID, STATEMENT COVERS PERIOD - FROM/THRU, R CODE

856 - SUSPCT DUPE 03 TO 05 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** RECIPIENT ID, STATEMENT COVERS PERIOD - FROM/THRU, R CODE, MEDICAL ASSISTANCE ID NUMBER, DATE OF EACH SERVICE, PROCEDURE CODE.

857 - SUSPCT DUPE 01 TO 06 - Dates of service, type of service, procedure code and procedure modifier should not be the same.

858 - SUSPCT DUPE 03 TO 07 -Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** RECIPIENT ID, STATEMENT COVERS PERIOD - FROM/THRU, R CODE, MEDICAL ASSISTANCE ID NUMBER, DATE OF EACH SERVICE, PROCEDURE CODE.

859 - SUSPCT DUPE 03 TO 08 - Dates of service, type of service, procedure code and procedure modifier should not be the same.

860 - SUSPCT DUPE 03 TO 09 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** RECIPIENT ID, STATEMENT COVERS PERIOD - FROM/THRU, R CODE, INSURED'S ID NUMBER, DATE OF SERVICE, PROCEDURE CODE

861 - SUSPCT DUPE 03 TO 13 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** RECIPIENT ID, STATEMENT COVERS PERIOD - FROM/THRU, R CODE, MEDICAL ASSISTANCE ID NUMBER, DATE OF CURRENT SCREENING

862 - SUSPCT DUPE 03 TO 15 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** RECIPIENT ID, STATEMENT COVERS PERIOD - FROM/THRU, R CODE, INSURED'S ID NUMBER, DATE OF SERVICE

863 - SUSPCT DUPE 04 TO 04 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** INSURED'S ID NUMBER, DATES OF SERVICE, PROCEDURE CODE

864 - SUSPCT DUPE 04 TO 15 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** INSURED'S ID NUMBER, DATES OF SERVICE, PROCEDURE CODE

865 - SUSPCT DUPE 05 TO 05 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, DATE OF EACH SERVICE, PROCEDURE CODE

866 - SUSPCT DUPE 05 TO 06 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, DATE OF EACH SERVICE, PROCEDURE CODE

867 - SUSPCT DUPE 05 TO 07 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, DATE OF EACH SERVICE, PROCEDURE CODE

868 - SUSPCT DUPE 05 TO 08 - Dates of service, type of service, procedure code and procedure modifier should not be the same.

869 - SUSPCT DUPE 05 TO 09 - Dates of service, type of service, procedure code and procedure modifier should not be the same.

870 - SUSPCT DUPE 05 TO 13 - Dates of service, type of service, procedure code and procedure modifier should not be the same.

871 - SUSPCT DUPE 05 TO 14 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, DATE OF SERVICE, PROCEDURE CODE, RECIPIENT ID, STATEMENT COVERS PERIOD - FROM/THRU, DESCRIPTION (PROCEDURE CODE)

872 - SUSPCT DUEP 06 TO 06 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, DATE OF SERVICE, SERVICE CODE

873 - SUSPCT DUPE 06 TO 07 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, DATE OF SERVICE, SERVICE CODE

874 - SUSPCT DUPE 06 TO 08 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, DATE OF SERVICE, SERVICE CODE

875 - SUSPCT DUPE 06 TO 09 - Dates of service, type of service, procedure code and procedure modifier should not be the same.

876 - SUSPCT DUPE 06 TO 13 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, DATE OF SERVICE, SERVICE CODE

877 - SUSPCT DUPE 06 TO 14 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, DATE OF SERVICE, SERVICE CODE, RECIPIENT ID, STATEMENT COVERS PERIOD - FROM/THRU, DESCRIPTION (PROCEDURE CODE)

878 - SUSPCT DUPE 07 TO 07 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, DATE OF SERVICE, PROCEDURE CODE

879 - SUSPCT DUPE 07 TO 08 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, DATE OF SERVICE, PROCEDURE CODE

880 - SUSPCT DUPE 07 TO 09 - Dates of service, type of service, procedure code and procedure modifier should not be the same.

881 - SUSPCT DUPE 07 TO 13 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, DATE OF SERVICE, PROCEDURE CODE, DATE OF CURRENT SCREENING

882 - SUSPCT DUPE 07 TO 15 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, DATE OF SERVICE, PROCEDURE CODE, INSURED'S ID NUMBER

883 - SUSPCT DUPE 08 TO 08 - Suspected duplicate error - Identical non-ambulance claims. **STATUS -**O

884 - SUSPCT DUPE 08 TO 09 - Dates of service, type of service, procedure code and procedure modifier should not be the same.

885 - SUSPCT DUPE 08 TO 13 - Dates of service, type of service, procedure code and procedure modifier should not be the same.

886 - SUSPCT DUPE 08 TO 15 - Dates of service, type of service, procedure code and procedure modifier should not be the same.

887 - SUSPCT DUPE 09 TO 09 - Dates of service, type of service, procedure code and procedure modifier should not be the same.

888 - SUSPCT DUPE 09 TO 13 - Dates of service, type of service, procedure code and procedure modifier should not be the same.

889 - SUSPCT DUPE 09 TO 15 - Dates of service, type of service, procedure code and procedure modifier should not be the same.

890 - SUSPCT DUPE 10 TO 10 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** MEDICAL ASSISTANCE ID NUMBER, TOOTH NUMBER OR LETTER, SURFACE, PROCEDURE CODE

891 - SUSPCT DUPE 10 TO 11 - Dates of service, type of service, procedure code and procedure modifier should not be the same.

892 - SUSPCT DUPE 11 TO 11 - Suspected duplicate error - Identical Dental-Adult claims. **STATUS -**O

893 - SUSPCT DUPE 12 TO 12 - Suspected duplicate error - Identical Pharmacy claims. **STATUS -**O

894 - SUSPCT DUPE 13 TO 13 - Suspected duplicate error - Identical EPSDT claims. **STATUS -**O

895 - SUSPCT DUPE 13 TO 15 - Dates of service, type of service, procedure code and procedure modifier should not be the same.

896 - SUSPCT DUPE 14 TO 14 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** RECIPIENT ID, STATEMENT COVERS PERIOD - FROM/THRU

897 - SUSPCT DUPE 15 TO 15 - Dates of service, type of service, procedure code and procedure modifier should not be the same. **Fields -** INSURED'S ID NUMBER, DATES OF SERVICE. **STATUS -**D

898 - EXACT DUPE SAME ICN - Exact duplicate, same ICN - dropped. **STATUS -**D

899 - SUSPCT DUPE 12 TO 15 - Dates of service should not be equal and procedure code/ NDC should not be the same. **Fields -** DATES OF SERVICE, NAT'L DRUG CODE, PROCEDURE CODE

900 - LIFETIME LIMITS-ONE - Only one newborn hospital care allowed per recipient. **STATUS -**D

901 - UNITS WERE CUTBACK - Service limits should not be exceeded. If so, a partial or full cutback will be applied. **STATUS -**T

902 - LTC HOME-LOA OVER 14 - Long term care leave days must not exceed limit of 14 home leave days. **STATUS -**E

903 - NEEDS MANUAL CUTBACK - Must not exceed daily limit. Is exceeded, partial payment is manually applied. **STATUS -**O

904 - SVC BEYOND TIME LIM - Service must be performed within required time specifications. **STATUS -**D

905 - LTC MED-LOA OVER 15 - Long term care leave days must not exceed limit of 15 per hospital stay. **STATUS -**E

906 - EXCEEDS MAX ALLOWED - Must not exceed maximum allowed.

907 - PHY/CLINIC OVER MAX - Physician and/or clinic visits must not exceed annual maximum. **STATUS -**D

908 - HH VISIT OVER 50 - Home health visits must not exceed annual maximum allowed (50). **STATUS -**D

909 - LTC HOME LVD OVER 9 - Long term care leave must not exceed annual maximum allowed (9). **STATUS -**E

910 - ICF-MR LIMIT OVER 45 - ICF-MR home leave must not exceed annual maximum allowed (45). **STATUS -**E

911 - HOSP DAYS OVER MAX - Hospital days must not exceed annual maximum allowed. **STATUS -**D

912 - PENICL INJ OVER 12 - Penicillin/Bicillin injections must not exceed annual allowed (12). **STATUS -**D

913 - PHY/HOSP VIS OVER MAX - Physician hospital visits must not exceed annual maximum. **STATUS -**D

914 - CHIROP ENCNTR MAX - Chiropractic encounter maximum reached. **STATUS -**D

915 - EMERG OP OVER 3 - Emergency outpatient visits must not exceed annual maximum (3). **STATUS -**D

916 - NON-EMERG OP OVER 12 - Non-emergency outpatient visits must not exceed maximum of (12). **STATUS -**D

917 - OVER LIFETIME LIMIT - Must not exceed the lifetime limit for this service.

918 - REDUCED BY TPL - Medicaid allowable amount reduced by other insurance. **STATUS -**E

919 - REDUCED BY SPEND DOWN - Medicaid allowable amount reduced by recipient spend down. **STATUS -**E

920 - OVER 5 REFILLS - More than 5 refills per prescription are not reimbursable. **STATUS -**D

921 - REMOV DNT PROSTHESI - Must not be more than 1 removable dental prosthesis billed per 5 years. Codes D5820, D5210, D5821, and D5211.

922 - EOMB MUST ATTACH - Medicare EOMB must be present and valid. **STATUS -**E

923 - CHIROP E&M VISIT MAX - Must not reach the maximum chiropractic E&M. **STATUS -**D

924 - PVT.RM NOT CERTIFIED - Private room must be certified by physician. **STATUS -**E

925 - SEND RECORDS FOR DOS - Office records for date of service must be sent. **STATUS -**E

926 - EXACT DUPLICATE - Exact duplicate of another adjustment. **STATUS -**D

927 - OFS FORMS MISSING - OFS forms 158B and acknowledgement required. **STATUS -** E

928 - PSRO-0 DAYS APPROVED - PSRO did not approve this stay. **STATUS -**E

929 -MILES EXCEED MAXIMUM - When miles are greater than allowed, state approval is required. **STATUS -**E

930 - BILL ONE PROC.PER L - Bill one procedure per line for each date of service. **STATUS -**E

931 - PURS. THIRD PARTY LIB - Pursue third party liability and reimburse Med. Assistance Program. **STATUS -**E

932 - BILL 3RD PARTY CARRI - Please bill third party carrier first. **STATUS -**D

933 - PRV SIG INVD - Provider signature must be present and valid. **STATUS -**E

934 - CLAIM REQUIRES RX - Claim requires prescription. **STATUS -**E

935 - BATCHED INCORRECTLY - Re-enter, batched incorrectly. **STATUS -**E

936 - PROCESSING ERROR - STATUS -E

937 - ONLY ONE DATE OF SER - Only one date of service per claim line. **STATUS -**E

938 - SPLIT BILL ACC RATE - Split bill when accommodation rate changes. **STATUS -**E

939 - CUTBACK PER SURS - Cutback per SURS guidelines. **STATUS -**E

940 - DENY TO BE REBILLED - Medicare denied. If covered, bill with provider EOB. **STATUS -**E

941 - DENIED PER SURS - Denied per SURS guidelines. **STATUS -**E

942 - DENY, NOT TO REBILL - Denied by Medicare, not covered by Medicaid. **STATUS -**D

943 - SPEND DOWN FORM - Spend down form 110MNP must be present and valid. **STATUS -**E

944 - NOT PAID BY MEDICARE - STATUS -E

945 - SPLIT BILL ACC. RATE - Split bill when accommodation blood rate changes. **STATUS -**E

946 - SPLIT BILL FOR PART. - Split bill for partial eligibility. **STATUS -**E

947 - RECIPIENT/PHYSICIAN - Recipient/physician date/signature must be present on the consent form. **STATUS -**E

948 - INC IN MAJ SUR PROC - Included in major surgical procedure. **STATUS -**E

949 - ANESTH TIME MISSING - Anesthesia minutes must be present and valid. **STATUS -**E

950 - OPER&HIST REPT REQ - Attach both operative and history report. **STATUS -**E

951 - DISCH DATE NOT COV - Date of discharge not covered. **STATUS -**E

952 - INC IN OV/RELAT PROC - Included in office visit or related procedure. **STATUS -**E

953 - JUSTIFY 22 MOD - Resubmit with justification for use of 22 modifier. **STATUS -**E

954 - PROC INAPPROPRIATE - Procedure must be appropriate. See CPT for valid code. **STATUS -**E

955 - PAID ACC TO MED REV - Paid according to Medical Review. **STATUS -**E

956 - PROC/DX AGE RESTRICT - Procedure/DX must be covered for a recipient of this age. **STATUS -**E

957 - PROC/DIAG NO MED NEC - Procedure and/or diagnosis must be deemed medically necessary. **STATUS -**E

958 - DENY BY MED REVIEW - Denied according to Medical Review guidelines. **STATUS -**E

959 - RESUB SURGEONS CODE - Resubmit claim using code surgeon billed. **STATUS -**E

960 - BHSF AUTH NEEDED - BHSF authorization letter for transplant must be attached. **STATUS -**E

961 - DENY OVER 99 DYS BIL - Deny over 99 days billed must be split bill. **STATUS -**E

962 - NEWBORN CHARGES - Newborn services. Bill under newborn number. **STATUS -**E

963 - PROC./DIAG DESP.REQ - Procedure/diagnosis description required. **STATUS -**E

964 - CONSULTATION REFER. - Referring physician required for consultation claim. **STATUS -**E

965 - NOT COVERED BE HH - Service not covered by Home Health Program. **STATUS -**D

966 - CLAIM HARD COPY NEED - Hard copy of claim must be submitted. **STATUS -**D

967 - BOTH PROV ARE INDIVI - If the attending provider is present, then the billing provider must be a group. **STATUS -**D

968 - PROC/SERV REND CONF - Procedure codes must reflect services rendered. **STATUS -**E

969 - BILL PEDIATRIC CODES - Bill pediatric codes for well children. **STATUS -**E

970 - INAPPROPRIATE CODE - Inappropriate code. Bill lab or specific handling. **STATUS -**D

971 - MEDICARE CLAIM >6 MO - The date of receipt must not be older than one year from the date of service and the Medicare payment must not be greater than six months from the date of receipt. **Fields -** STATEMENT COVERS PERIOD - FROM/THRU, MEDICARE PAID DATE, JULIAN DATE ON CLAIM, DATES OF SERVICE.

972 - MEDICARE PAID 100% - Allowable amount paid in full by Medicare. **STATUS -**D

973 - NO SURGERY MOD - Claim description indicates procedure code should have a modifier. **STATUS -**E

974 - DIA CODE/DESC CONF - Diagnosis code and description must not conflict. **STATUS -**E

975 - BLK 22 NOT COMPLETE - Block 22 must be completed. Lab work indicated. **STATUS -**E

976 - STAMPED SIGNATURE - Stamped signature not allowed. **STATUS -**D

977 - PROC/DX SEX RESTRICT - Procedure/DX inappropriate for this recipient's sex. **STATUS -**E

978 - CAL. PRICE IS ZERO - The program has calculated this payment to be zero. Call Help Desk.

979 - CLAIM IN PROCESS - STATUS -O

980 - INVALID ADJ REASON - Invalid adjustment reason. **STATUS -**E

981 - INVALID U&C OR PREV - Invalid U&C or prevailing fee. **STATUS -**E

982 - OVERRIDE ZERO PAID - Override. Provider paid amount of zero. **STATUS -**E

983 - SYS CALC NET TOTAL - System calculated total. Net billed not in balance. **STATUS -**E

984 - CRG INCL IN PD CLAIM - Charges included in paid claim for mother. **STATUS -**E

985 - REBILL-MOTHERS INFO - Rebill under mothers name and MID number. **STATUS -** E

986 - REBILL-BABYS INFO - Rebill baby's MID and mothers D/C date as baby's admit date. **STATUS -**E

987 - DENIED TO REBILL/ADJ - Denied to be rebilled on adjustment form. **STATUS -**E

988 - COVERED BY MEDICARE - Item covered by Medicare.

989 - WAIT TIME > 6 HRS PA - Wait time is greater than 6 hours. Must have state approval. **STATUS -**E

990 - 2 PROC SAME TOOTH/DAY - Emergency/definitive not payable on same tooth on the same day. **STATUS -**E

991 - PROCEDURE IN PANEL - Procedure included in panel. **STATUS -**E

992 - B/D = OR LESS 1902 - Rec. B/D equals or is less than 1902, bill Medicare. **STATUS -**D

993 - MID CORRECTED - MID has been corrected. Please update your files. **STATUS -**E

994 - CLAIM NO LEGIBLE - Claim must be legible. If unable to read - please resubmit. **STATUS** -D

995 - PAT. PAYMENT NOT ALL - Patient payment not allowed. **STATUS** -D

996 - MC PAYMENT REDUCED - Deductible and/or co-insurance reduced to maximum allowable. **STATUS** -E

997 - COMP A -MODE ECHOENCH - Complete A-Mode Echoenchephalography. Bill HCPC Z9100.

998 - LEG. ADT TEST CLAIMS - Legislative audit test claims. **STATUS** -DF

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