CDE_EOB	DSC_EOB	CDE_ADJ_RSN	CDE_GROUP
0000	INACTIVE ERROR CODE. MODIFIED	96	CO
0001	INTERNAL EDIT.	96	CO
0002	PROCESSED IN ERROR. CLAIM WILL BE REPROCESSED.		
0003	CLAIM DENIED. FIX ERRORS AND RESUBMIT		
0040	CLAIM PAID BEYOND TIMELY FILING LIMIT DUE TO SPECIAL HANDLING		
0050	PROGRAM RESTRICTIONS BYPASSED DUE TO TPL.	22	CO
0084	PARTIAL RECOUPMENT.	172	CO
0091	REDUCED TO MAXIMUM ALLOWED ON PRIOR AUTHORIZATION FILE.	197	CO
0093	WE HAVE DEDUCTED THE ORIGINAL PAYMENT AS A RESULT OF A PAYMENT APPEAL.	129	CO
0094	PAYMENT AMOUNT REDUCED BY EXCESS ASSETS.	178	CO
0097	PAYMENT REDUCED BY OTHER INSURANCE/ADJUSTMENT TO PAYMENT AMOUNT.	23	CO
0100	REDUCE TO MAXIMUM ALLOWED ON PRIOR AUTHORIZATION FILE.	197	CO
0102	SERVICE IS NOT COVERED FOR ELIGIBILITY DETERMINATION.	96	CO
0107	PAID AMOUNT REDUCED BY OTHER INSURANCE AND COPAY.	22	CO
0108	PAID AMOUNT REDUCED TO ZERO BY OTHER INSURANCE AND COPAY.	22	CO
0109	AMOUNT REFLECTS MONIES RECOUPED FOR MEDICARE COVERED SERVICES.	22	CO
0111	MEDICARE RECONSIDERATION ADJUSTMENT.	195	CO
0113	CLAIM/DETAIL PAID USING FQHC PRICING.	172	CO
0131	PAYMENT AMOUNT REFLECTS COMPOSITE PANEL RATE.	B5	CO
0135	DENIED. CLAIM CORRECTION FORM RESPONSE NOT RECEIVED OR INSUFFICIENT TO PROCESS.	16	CO
0137	HMS SPECIAL PROJECT RECOUPMENT-FULL.	172	CO
0157	NDC IS MISSING.	16	CO
0158	CLAIM/DETAIL PAID PARTIAL CO-INSURANCE AND DEDUCTIBLE BILLED.	23	CO
0159	CLAIM/DETAIL PAID PARTIAL DEDUCTIBLE BILLED.	23	CO
0161	CLAIM/DETAIL DENIED BY MEDICARE.	23	CO
0164	CLAIM/DETAIL PAID IN FULL BY MEDICARE.	23	CO
0165	MEDICARE PAYMENT IS EQUAL TO OR EXCEEDS MEDICAID ALLOWED CHARGE.	23	CO
0169	NO CO-INSURANCE OR DEDUCTIBLE DUE.	23	CO
0171	PAYMENT AMOUNT REDUCED BY APPLIED INCOME.	142	PR
0177	PAYMENT AMOUNT REFLECTS RENT TO PURCHASE PRICING.	B5	CO
0188	THIS SAGA CLAIM HAS BEEN RECOUPED AND RESUBMITTED AS A MEDICAID CLAIM.	177	PR
0195	RETROACTIVE DATE OF DEATH ADJUSTMENT.	13	OA
0201	Billing provider identifier is missing.	B7	CO
0202	Billing provider identifier is invalid.	B7	CO
0203	Client identification number is missing.	31	CO
0204	PRESCRIBING PROVIDER NOT AUTHORIZED TO PRESCRIBE		
0205	PRESCRIBING PROVIDER'S NPI, DEA OR LICENSE IS MISSING.	16	CO
0206	SUBMITTED PRESCRIBER'S ID IS INVALID.	125	CO
0207	PRESCRIBER NOT ENROLLED-CLAIMS WILL DENY 9/1/2013		
0208	PREGNANCY INDICATOR INVALID		
0209	PRESCRIBER ID OF GROUP; RESUBMIT INDIVIDUAL'S NPI		
0210	DISPENSE AS WRITTEN INVALID.	125	CO
0211	REFILL INDICATOR IS MISSING OR INVALID.	16	CO
0212	PRESCRIPTION NUMBER IS MISSING.	16	CO
0213	DATE PRESCRIPTION WRITTEN IS MISSING.	16	CO
0214	DATE PRESCRIPTION WRITTEN IS INVALID.	125	CO
0215	DATE DISPENSED IS MISSING.	16	CO
0216	DATE DISPENSED IS INVALID.	125	CO
0217	GENERIC RETROACTIVE ME ADJUSTMENT.	B5	CO
0218	NDC IS INVALID.	125	CO
0219	QUANTITY DISPENSED IS MISSING.	16	CO
0220	QUANTITY DISPENSED IS INVALID.	125	CO
0221	DAYS SUPPLY IS MISSING.	16	CO
0222	DAYS SUPPLY IS INVALID.	125	CO
0223	Required ICD-9-CM diagnosis code is missing or invalid.	16	CO
0224	Detail diagnosis code pointer invalid on paper claim.	125	CO
0225	PATIENT LIABILITY ADJUSTMENT.	142	PR
0226	Referring provider name/number is missing.	16	CO
0227	OTHER PAYER PAYMENT AMOUNT IS INVALID	16	CO
0229	The source of admission is missing or invalid.	16	CO
0231	Performing provider is missing.	16	CO
0232	RATE CHANGE ADJUSTMENT.	172	CO
0233	Number of days, visits or units of service is missing.	16	CO
0234	PROCEDURE CODE IS MISSING OR INVALID.	16	CO
0235	PROCEDURE CODE NOT IN VALID FORMAT		
0238	Client's last name is missing.	16	CO
0239	The submitted claim detail through date of service is missing.	16	CO
0240	The submitted claim detail through date of service is invalid.	125	CO
0241	Accident code is invalid.	125	CO
0242	Secondary diagnosis code submitted in an invalid format.	125	CO
0244	Third diagnosis code submitted in an invalid format.	125	CO
0246	Fourth diagnosis code submitted in an invalid format.	125	CO

CDE_EOB	DSC_EOB	CDE_ADJ_RSN	CDE_GROUP
0247	Exceeds maximum number of claim details allowed.	125	CO
0248	Facility type code is missing.	16	CO
0249	Facility type code is invalid.	125	CO
0250	Claim submitted without any services billed.	16	CO
0251	FIRST MODIFIER IS INVALID.	B18	CO
0252	SECOND MODIFIER IS INVALID.	B18	CO
0253	THIRD MODIFIER IS INVALID.	B18	CO
0258	Primary diagnosis code is missing or invalid	16	CO
0260	UNITS OF SERVICE IS INVALID.	125	CO
0261	Tooth number is missing.	16	CO
0262	Tooth number is invalid.	125	CO
0263	Tooth surface is invalid.	125	CO
0264	DETAIL DATE OF SERVICE IS MISSING.	16	CO
0265	DETAIL DATE OF SERVICE IS INVALID.	125	CO
0268	DETAIL BILLED AMOUNT IS MISSING.	16	CO
0269	DETAIL BILLED AMOUNT IS INVALID.	16	CO
0270	TOTAL CHARGE IS MISSING OR ZERO.	16	CO
0271	TOTAL CHARGE IS INVALID.	16	CO
0273	Type of bill is missing.	16	CO
0274	Type of bill is invalid.	125	CO
0275	Admission date is missing.	16	CO
0276	Admission date is invalid.	125	CO
0277	Admission hour is missing or invalid.	16	CO
0278	Admission type is missing.	16	CO
0279	Admission type is invalid.	125	CO
0280	Patient status is missing.	16	CO
0281	Patient status is invalid.	125	CO
0339	Revenue center code is missing.	16	CO
0340	Revenue center code is invalid.	125	CO
0350	Submitted number of details not equal to header submitted detail count field.	125	CO
0360	ADMITTING DIAGNOSIS MISSING.	16	CO
0361	ADMITTING DIAGNOSIS CODE INVALID.	125	CO
0363	PRINCIPAL PROCEDURE CODE INVALID.	125	CO
0364	Surgical procedure and date required when operating physician is present.	16	CO
0365	PRINCIPAL PROCEDURE DATE IS INVALID OR PRINCIPAL PROCEDURE CODE IS MISSING	125	CO
0366	FIRST OTHER PROCEDURE CODE INVALID.	125	CO
0367	Second procedure code or date is missing.	16	CO
0368	Second procedure date is invalid.	125	CO
0369	SECOND OTHER PROCEDURE CODE INVALID.	125	CO
0370	Third procedure code or date is missing.	16	CO
0371	Third procedure date is invalid.	125	CO
0372	The fourth surgical procedure code is invalid.	B18	CO
0373	The fourth surgical procedure code or date is missing.	16	CO
0375	The fifth surgical procedure code is invalid.	B18	CO
0376	The fifth surgical procedure code or date is missing.	16	CO
0381	Attending provider number is missing.	16	CO
0389	Required procedure code is missing.	16	CO
0390	REVENUE CENTER CODE REQUIRES A HCPC/PROCEDURE CODE		
0391	REVENUE CENTER REQUIRES A HCPC/PROCEDURE CODE	16	CO
0392	REVENUE CENTER CODE REQUIRES A HCPC/PROCEDURE CODE		
0395	The from date of service is missing.	16	CO
0396	The from date of service is invalid.	125	CO
0397	Through date of service is missing.	16	CO
0398	Through date of service is invalid.	125	CO
0400	DETAIL UNITS MUST BE GREATER THAN ZERO.	125	CO
0401	The net charge is missing or invalid.	16	CO
0433	MEDICARE DEDUCTIBLE AMOUNT INVALID		
0436	TOTAL MEDICARE ALLOWED AMOUNT INVALID		
0450	Invalid area of oral cavity billed.	125	CO
0451	No Medicare coinsurance or deductible billed.	22	CO
0454	Benefits assignment code is invalid. Contact the Provider Assistance Center.	B5	CO
0457	INVALID SURGICAL PROCEDURE CODE QUALIFIER SUBMITTED		
0459	Detail diagnosis code pointer invalid on electronic claim.	125	CO
0500	DATE PRESCRIBED IS AFTER THE DATE OF SUBMISSION.	110	CO
0502	DATE DISPENSED IS EARLIER THAN THE DATE PRESCRIBED.	125	CO
0503	DATE DISPENSED IS AFTER SUBMISSION DATE.	110	CO
0505	Total other insurance/spenddown amount is > or = the billed amount.	23	CO
0507	The through date of service is before the from date of service.	125	CO
0508	Total charges do not equal the sum of all detail charges.	16	CO
0509	THE NET CHARGE IS OUT OF BALANCE.	16	CO
0512	CLAIM EXCEEDS TIMELY FILING LIMIT.	29	CO
0513	Client's name and number disagree.	140	CO

CDE_EOB	DSC_EOB	CDE_ADJ_RSN	CDE_GROUP
0514	The through date of service contains a future date.	110	CO
0515	CHARTER OAK 120 DAY TIMELY FILING LIMIT EXCEEDED		
0516	CLAIM IS PAST 180 DAY FQHC TIMELY FILING LIMIT.		
0518	Total accommodation days billed are not equal to the elapsed days.	125	CO
0519	Admission date is after the from date of service.	125	CO
0521	The through date of service is after the discharge date.	125	CO
0526	The from date of service is illogical.	125	CO
0527	Detail from date of service is after date of submission.	110	CO
0529	Surgical procedure date is prior to admission date.	125	CO
0530	Surgical procedure date is after patient discharge date.	125	CO
0532	DISEASE STATE MANAGEMENT.		
0533	PDUR DRUG-ALLERGY INTERACTION.		
0534	PRODUR DRUG-AGE INTERACTION.		
0535	PDUR INGREDIENT DUPLICATION.		
0536	PDUR THERAPEUTIC DUPLICATION.		
0537	PDUR DRUG-TO-DRUG INTERACTION.		
0539	PDUR EARLY REFILL ON PRESCRIPTION.		
0540	PDUR MINIMUM DURATION.		
0541	PDUR DOSING PRECAUTION-HIGH DOSE.		
0542	PDUR DOSING PRECAUTION-LOW DOSE.		
0543	PDUR BREAST FEEDING/PREGNANCY PRECAUTION.		
0544	PDUR MAXIMUM DURATION OF THERAPY.		
0545	CLAIM EXCEEDS TIMELY FILING LIMIT.	29	CO
0546	DRUG DISEASE MARKER.		
0547	PDUR LATE REFILL ON PRESCRIPTION.		
0550	ELECTRONIC ADJUSTMENT IS INVALID.	45	CO
0551	PROVIDER ID ON ADJUSTMENT DOES NOT MATCH MOTHER		
0555	Claim is past Behavioral Health timely filing guidelines.	29	CO
0559	Medicare coinsurance amount is greater than the Medicare paid amount.	125	CO
0568	The admission date is after the discharge date.	125	CO
0570	HEADER TOTAL DAYS LESS THAN COVERED DAYS.	125	CO
0571	Primary surgical procedure required when surgical RCC is billed.	16	CO
0572	Quantity disagrees with days elapsed.	125	CO
0574	Dates of service cannot span calendar months.	125	CO
0575	Primary or secondary surgical date is outside of the claims dates of service.	125	CO
0589	MASS ADJUSTMENT		
0592	CLAIM EXCEEDS TIMELY FILING LIMIT.	29	CO
0600	The number of quadrants billed does not equal the number of units billed.	125	CO
0601	ONLY QUADRANT, NOT TOOTH NUMBER, ALLOWED FOR THIS PROCEDURE CODE.		
0604	ONLY 1 QUADRANT ALLOWED PER CLAIM DETAIL		
0608	COMPOSITES NOT COVERED FOR CLIENTS 21 OR OLDER FOR FIRST OR SECOND MOLAR TEETH.		
0615	PATIENT REASON FOR VISIT INVALID		
0616	ICD10 DX QUALIFIER SUBMITTED PRIOR TO EFF DATE		
0617	INVALID CLAIM VERSION - SUBMIT IN NEW HIPAA 5010		
0618	BILLING PROVIDER ADDRESS CANNOT CONTAIN PO BOX		
0619	ZIP CODE IS NOT A VALID 9 DIGIT ZIP CODE		
0620	SERVICE FACILITY ZIP CODE IS INVALID		
0621	BILLING PROV ENTITY TYPE QUALIFIER TO PROV TYPE/SPECIALTY MISMATCH		
0622	RENDERING PROVIDER TYPE/SPECIALTY CONFLICT WITH ENTITY TYPE QUALIFIER		
0643	Other Insurance indicator is missing or invalid.	16	CO
0670	CLAIM TYPE NOT COVERED FOR CLIENT WITH INMATE INPATIENT HOSPITAL LOCK-IN COVERA		
0700	RESPITE OR CONTINUOUS CARE NOT ALLOWED FOR CLIENTS IN A NURSING FACILITY	B5	CO
0701	HOSPICE ROOM AND BOARD NOT COVERED FOR ICF/MR PROVIDER TYPE AND SPECIALTY.	B5	CO
0702	HOSPICE ROOM AND BOARD NOT COVERED WITHOUT NURSING HOME AUTHORIZATION.	B5	CO
0703	HOSPICE REQUIRED HOURS NOT MET	B5	CO
0704	RCC NOT ALLOWED FOR HOSPICE CLIENT	199	CO
0705	OUTPATIENT CLAIM FOR HOSPICE CLIENT REQUIRES CONDITION CODE	B5	CO
0706	SERVICE NOT COVERED FOR HOSPICE CLIENT	B9	CO
0707	HOSPICE RADIOLOGY SERVICES REQUIRE MODIFIER	4	CO
0708	CROSOVER NOT COVERED FOR HOSPICE		
0709	PHARMACY SERVICE NOT COVERED FOR HOSPICE CLIENT		
0710	REVENUE NOT COVERED FOR CLIENT ENROLLED IN MEDICARE HOSPICE.		
0711	CLAIM DENIED. CLIENT DOES NOT HAVE HOSPICE LOCK-IN.		
0720	MODIFIER NOT COVERED - OTHER PROVIDER PREVENTABLE CONDITIONS		
0721	DIAGNOSIS NOT COVERED - OTHER PROVIDER PREVENTABLE CONDITIONS		
0730	NEMT BROKER TP ID IS NOT PRESENT ON NON-EMERGENCY TRANSPORTATION CLAIM		
0731	NEMT CLAIMS IS BILLED FOR OUT OF STATE PROVIDER		
0750	CHC PROCEDURE NOT BILLABLE WITH OTHER PROCEDURES		
0751	BIRTH WEIGHT REQUIRED WITH ADMIT TYPE OF '4' (NEWBORN)		
0752	PRESENT ON ADMISSION INDICATOR MISSING OR INVALID	16	CO
0779	ENCOUNTER CLAIMS NOT PAYABLE FOR DATES OF SERVICE AFTER 12/31/2011.		
0780	PRICED AT ENCOUNTER PAID AMOUNT		

CDE_EOB	DSC_EOB	CDE_ADJ_RSN	CDE_GROUP
0781	DATE OF SERVICE PRIOR TO HP ENCOUNTER SUBMISSION.		
0782	NETWORK BILLING PROVIDER REQUIRED FOR ENCOUNTER.		
0783	NETWORK PERFORMING PROVIDER REQUIRED FOR ENCOUNTER.		
0784	INVALID ENCOUNTER ADJUSTMENT		
0785	OTHER PAYER ID INCONSISTENT WITH SUBMITTER.		
0786	INVALID SUBMITTER ID FOR ENCOUNTER.		
0788	ENOCUNTER SUBMITTED FOR INVALID CLAIM TYPE		
0789	ENCOUNTER OTHER PAYER ICN IS MISSING		
0790	ENCOUNTER DENIED DETAIL		
0791	ZERO PAID ENCOUNTER CLAIM		
0792	SUSPECT PROVIDER MATCH		
0800	LOCATION CODE INVALID.	16	CO
0801	QUANTITY BILLED DOES NOT EQUAL PACKAGE SIZE.	125	CO
0802	PROVIDER QUALIFIER MISSING OR INVALID.	16	CO
0803	THE PATIENT CONTROL NUMBER IS MISSING.	16	CO
0804	PRESCRIPTION QUALIFIER IS INVALID.	125	CO
0805	PRESCRIBER QUALIFIER IS INVALID.	125	CO
0806	M/I OTHER PAYER ID QUALIFIER	125	CO
0807	Diagnosis code qualifier is invalid.	125	CO
0808	Other amount claimed submitted qualifier is missing or invalid.	16	CO
0809	Other insurance carrier code is missing, invalid or not applicable.	16	CO
0810	The other insurance amount is missing or not applicable.	16	CO
0811	CONNPACE CLAIM WITH OTHER INSURANCE PAYMENT IS NOT COVERED.	22	CO
0812	Patient status is not billable for the Connecticut Medical Assistance Program.	96	CO
0813	Claim denied after Medical Policy review.	95	CO
0814	CLAIM DENIED FOR MEDICAL POLICY REVIEW.	95	CO
0815	CLIENT'S LAST NAME IS NOT VALID.	140	CO
0816	CLIENT'S FIRST NAME IS NOT VALID.	140	CO
0817	Client's first name is missing.	16	CO
0818	Invalid processor control number.	125	CO
0819	REJECT CODE REQUIRED.	16	CO
0820	REJECT CODE NOT ACCEPTED FOR TPL BILLING.	16	CO
0821	Nursing home dates of service not payable when billed in current month.	A1	CO
0822	Crossover with missing/invalid data.	16	CO
0824	OTHER INSURANCE CARRIER CODE IS MISSING		
0825	CLIENT NAME DISAGREES WITH NAME ON FILE		
0826	INVALID PROCESSOR CONTROL NUMBER. USE CTPCNPTD.		
0827	INVALID PROCESSOR CONTROL NUMBER. USE CTPCNPVT		
0828	INVALID PROCESSOR CONTROL NUMBER. USE CTPCNFMD.		
0829	REJECT CODE NOT ACCEPTED FOR TPL BILLING.	16	CO
0830	OTHER AMOUNT SUBMITTED INVALID FOR COVERAGE CODE		
0831	MISSING/INVALID PATIENT RESIDENCE (384-4X)		
0832	DATE OF BIRTH MISSING (304-C4)		
0833	DATE OF BIRTH INVALID (304-C4)		
0834	MISSING/INVALID PATIENT GENDER (305-C5)		
0835	PROVIDER SPECIALTY CHANGED FOR PORTION OF CLAIM. SUBMIT SEPARATE CLAIM FOR E		
0836	MISSING/INVALID PRESCRIPTION ORIGIN CODE (419-DJ)		
0837	MISSING/INVALID GROUP ID (301-C1)		
0838	M/I PATIENT RESPONSIBILITY AMOUNT QUALIFIER (351-NP)		
0839	NDC NOT VALID FOR PROCEDURE CODE BILLED		
0840	HCPC REQUIRED WHEN DRUG REVENUE CODE IS BILLED	B5	CO
0841	UNITS OF MEASURE REQUIRED FOR NDC	B5	CO
0842	NDC UNITS MISSING OR INVALID		
0843	TOO MANY VALUE CODES WITH MEDICARE COINSURANCE	B5	CO
0845	PROVIDER NOT ALLOWED TO BILL CLAIM TYPE		
0846	OTHER PAYER PATIENT RESPONSIBILITY AMOUNT INVALID FOR COVERAGE CODE		
0847	MDD CO-PAY ONLY CLAIM WITHOUT PRIMARY BILLING INFO, PLEASE CORRECT/RESUBMIT.		
0848	OCC CODE SUBMITTED WITHOUT PRIMARY PAYER INFO, PLEASE CORRECT/RESUBMIT.		
0849	REJECT CODE REQUIRED.	16	CO
0850	Medicare crossover claims containing deductible cannot span calendar years.	125	CO
0852	Accommodation days is zero.	125	CO
0853	Admission date is required for services performed in an inpatient hospital.	16	CO
0854	The from date of service must equal the first of the month.	125	CO
0855	NH LEAVE OF ABSENCE REQUIRES OCCURRENCE CODE/DATE		
0856	Required operating provider number is missing.	16	CO
0857	Overlapping detail dates of service.	125	CO
0858	Immunization administration procedure not covered without immunization code.	B15	CO
0859	RN services not covered without nursing care or nursing assessment service.	B15	CO
0860	LPN services not covered without nursing care services on same date of service.	B15	CO
0861	NDC IS MISSING OR INVALID.	16	CO
0862	Administratively necessary days for this RCC cannot exceed 7.	119	CO
0863	Detail dates of service not within header from and through dates of service.	125	CO

CDE_EOB	DSC_EOB	CDE_ADJ_RSN	CDE_GROUP
0864	Covered and non covered days disagree with total detail units.	125	CO
0865	Ambulance cannot bill mileage separately.	A1	CO
0866	Claim cannot exceed 31 days.	B5	CO
0867	Long Term Care detail dates of service are inconsistent with units billed.	125	CO
0868	LPN or RN services exceeded.	119	CO
0869	FQHC procedure not covered without other services.	B15	CO
0870	CLAIM/DETAIL PAID FULL CO-INSURANCE BILLED.	23	CO
0871	CLAIM/DETAIL PAID FULL CO-INSURANCE AND DEDUCTIBLE BILLED.	23	CO
0872	CLAIM/DETAIL PAID FULL DEDUCTIBLE BILLED.	23	CO
0873	MANUAL PRICE ERROR. CONTACT THE PROVIDER ASSISTANCE CENTER.	A1	CO
0874	Service included in hospital per diem rate.	97	CO
0875	HCPC not allowed with revenue center code.	96	CO
0876	HEADER QUANTITY DISAGREES WITH DAYS ELAPSED.	125	CO
0877	DETAIL QUANTITY DISAGREES WITH DAYS ELAPSED.	125	CO
0878	ALLOWED AMOUNT IS ZERO - CONTACT THE PROVIDER ASSISTANCE CENTER.	B5	CO
0879	NO CO-INSURANCE OR DEDUCTIBLE DUE FOR OUTPATIENT LAB SERVICES	96	CO
0880	MEDICARE PART B COINS/DEDUCT RECOUPMENT.	172	CO
0881	OTHER PAYER ID QUALIFIER NOT SUPPORTED	125	CO
0882	OTHER PAYER ID QUALIFIER NOT APPLICABLE	125	CO
0883	PATIENT RESP AMOUNT QUALIFIER NOT SUPPORTED		
0885	CLAIM/DETAIL PAID PARTIAL CO-INSURANCE BILLED.	23	CO
0888	PAYMENT AMOUNT REDUCED BY CLIENT DEDUCTIBLE	1	PR
0889	PAYMENT AMOUNT REDUCED BY CLIENT COINSURANCE	2	PR
0890	CHARTER OAK PAYMENT REDUCED BY CO-INSURANCE AND OR DEDUCTIBLE.		
0891	ANNUAL CHARTER OAK BENEFIT LIMIT MET		
0893	LIFETIME CHARTER OAK BENEFIT LIMIT MET		
0895	MH WAIVER PERFORMING PROVIDER MISSING OR NOT VALID PT/PS	B1	CO
0899	DENTAL FQHC PROCEDURE NOT PAYABLE		
0907	CLAIM DENIED. NO CHARTER OAK COST SHARE DATA FOR CLAIM DATES OF SERVICE.	16	CO
0912	PROVIDER TYPE AND SPECIALTY CANNOT BE FOUND		
0999	RECYCLE CLAIM TABLE OVERFLOW. CONTACT THE PROVIDER ASSISTANCE CENTER.	125	CO
1000	BILLING PROVIDER IDENTIFIER IS NOT ON FILE.	B7	CO
1001	BILLING PROVIDER INELIGIBLE ON DATE(S) OF SERVICE.	B7	CO
1003	BILLING PROVIDER INELIGIBLE ON DATE(S) OF SERVICE.	B7	CO
1004	PROVIDER NOT ALLOWED TO BILL FROM THIS SERVICE LOCATION		
1007	The performing provider is not on file.	B7	CO
1008	PERFORMING PROVIDER MUST HAVE AN INDIVIDUAL NUMBER		
1010	Performing provider is not a member of the billing provider group.	B7	CO
1011	PERFORMING PROVIDER NUMBER NOT A VALID FORMAT		
1013	PERFORMING PROVIDER NOT ACTIVE ON CLAIM DATE OF SERVICE		
1014	PERFORMING PROVIDER MUST BE ACTIVE		
1016	MANUFACTURER IS NOT PARTICIPATING IN DRUG REBATE ON DATE OF SERVICE DISPENSED.	B7	CO
1018	No rate on file. Contact the Provider Assistance Center.	B18	CO
1024	PROVIDER IS NOT AUTHORIZED TO BILL FOR THIS CLIENT.	B7	CO
1026	PRESCRIBING PROVIDER'S NPI IS NOT ON FILE.	208	CO
1031	SERVICE LOCATION PROVIDER NOT ENROLLED ON DATE OF SERVICE	B7	CO
1033	INFORMATIONAL ONLY - ATTENDING PHYSICIAN NOT ENROLLED ON DATE OF SERVICE	B7	CO
1034	INFORMATIONAL ONLY - RENDERING PROVIDER NOT ENROLLED ON DATE OF SERVICE	B7	CO
1035	INFORMATIONAL ONLY - REFERRING PROVIDER NOT ENROLLED ON DATE OF SERVICE	B7	CO
1036	INFORMATIONAL ONLY - ORDERING PROVIDER NOT ENROLLED ON DATE OF SERVICE	B7	CO
1051	Performing provider not on file.	B7	CO
1800	CLAIM MUST BE SUBMITTED ELECTRONICALLY.	A1	CO
1801	PROVIDER SANCTIONED BY DEPT OF HEALTH AND HUMAN SERVICES (HHS).	B7	CO
1802	Type of bill is invalid for the provider.	125	CO
1803	SOCIAL SECURITY NUMBER/EMPLOYER'S IDENTIFICATION NUMBER IS MISSING OR INVALID.	16	CO
1804	CROSSOVER CLAIMS ARE NOT PAYABLE FOR BEHAVIORAL HEALTH-ONLY PROVIDERS.		
1900	BILLING PROVIDER'S TAXONOMY IS INVALID		
1906	HEADER BILLING PROVIDER'S TAXONOMY IS NOT VALID		
1912	BILLING PROVIDER'S TAXONOMY IS MISSING	16	CO
1927	THE BILLING PROVIDER'S NPI IS MISSING OR INVALID.	16	CO
1928	The performing provider's NPI is missing or invalid on the claim.	16	CO
1931	The rendering provider's NPI is missing or invalid.	16	CO
1934	The performing provider's NPI is missing or invalid on the claim detail.	16	CO
1945	CLAIM/DETAIL DENIED. BILLING/PERFORMING PROVIDER COULD NOT BE DETERMINED.	16	CO
2001	CLIENT ID IS INVALID OR NOT ON FILE. REFERENCE ID CARD FOR CORRECT NUMBER.	31	CO
2002	CLIENT INELIGIBLE FOR DATES OF SERVICE.	177	PR
2003	CLIENT INELIGIBLE FOR DATES OF SERVICE.	177	PR
2010	CLIENT HAS NOT SATISFIED SPEND-DOWN.	177	PR
2017	SERVICE IS INCLUDED IN MCO COVERAGE.	24	CO
2057	Client ineligible for portion of claim. Resubmit for covered days only.	141	CO
2077	Client ineligible for portion of claim detail. Resubmit for covered days only.	141	CO
2078	CLIENT'S BENEFIT PLAN DOES NOT COVER CROSSOVER CLAIMS.	177	PR

CDE_EOB	DSC_EOB	CDE_ADJ_RSN	CDE_GROUP
2079	INCORRECT PROCEDURE CODE USED.	125	CO
2100	CLIENT NOT FOUND ON ELIGIBILITY MANAGEMENT SYSTEM.	177	PR
2101	CLIENT IS NOT ELIGIBLE ON ELIGIBILITY MANAGEMENT SYSTEM.	177	PR
2102	CLIENT ELIGIBILITY SYSTEM IS NOT CURRENTLY AVAILABLE.	177	PR
2103	UNABLE TO DETERMINE CLIENT ELIGIBILITY DUE TO INVALID CLIENT ID, INVALID DATE O	177	PR
2104	CONNPACE ID IS IN AN INVALID FORMAT		
2500	Bill Medicare first.	22	CO
2501	Bill Medicare first.	22	CO
2502	Bill Medicare first.	22	CO
2503	Bill Medicare first.	22	CO
2504	BILL PRIVATE CARRIER FIRST.	22	CO
2505	Bill private carrier first. Claim attachment is invalid.	22	CO
2506	HEADER AND DETAIL OTHER PAYER PAID AMOUNTS DO NOT BALANCE.	16	CO
2507	Client has more than one private insurance carrier.	22	CO
2508	PHARMACY MUST BILL PRIVATE CARRIER FIRST.	22	CO
2509	BILL MEDICARE FIRST.	22	CO
2513	OTHER PAYER ADJUDICATION DATE IS INVALID.	16	CO
2514	MEDICARE ELIGIBLE CLIENT MUST ENROLL IN PART D.	22	CO
2515	CLAIM OTHER PAYER CARRIER CODE IS NOT ON FILE.	125	CO
2516	Claim adjustment reason code is invalid.	204	CO
2516	Claim adjustment reason code is invalid.	125	CO
2517	CLAIM OTHER PAYER ADJUDICATION INFORMATION IS INCOMPLETE	125	CO
2518	Other Insurance Explanation of Benefits is missing	16	CO
2519	OTHER PAYER ADJUSTMENT AMOUNT IS INVALID	16	CO
2520	DUPLICATE CARRIER SUBMITTED		
2521	MEDICARE ELIGIBLE CLIENT MUST ENROLL IN PART D.		
2522	BILL MEDICARE FIRST OR PROVIDE APPROPRIATE ADJUSTMENT REASON CODE AND DAT		
2550	Other payer claim adjustment reason code restriction.	23	CO
2602	DATES OF SERVICE ARE OUTSIDE LOCK-IN EFFECTIVE DATES.	A1	CO
2603	PROVIDER NOT AUTHORIZED TO BILL FOR CLIENT.	B7	CO
2604	THIS CLIENT'S BENEFIT IS RETRICTED TO A SPECIFIC DIAGNOSIS.		
2800	DATE OF SERVICE SUBMITTED IS AFTER THE CLIENT'S DATE OF DEATH.	13	OA
2801	MEDICARE ELIGIBLE CLIENT MUST ENROLL IN PART D.	22	CO
2802	PROGRAM REQUIRES COPAY ONLY BILLING FOR MDD.	125	CO
2803	MED D COVERED DRUG - BILL MEDICARE FIRST.	22	CO
2804	Claim must be billed as crossover.	125	CO
2805	Date of service submitted is prior to client's date of birth.	14	OA
2806	COPAY-ONLY CLAIM > $5.00 NOT ALLOWED.	45	CO
2807	Client's date of birth is not on file. Contact DSS for eligibility corrrection.		
2808	SAGA CLAIM WITH DATES OF SERVICE PRIOR TO 4/1/2010 NO LONGER COVERED	45	CO
2809	MED D NF DRUG REQUIRES PA		
2810	ONE TIME BYPASS FILL HAS BEEN USED; EITHER MD HAS AGREED TO CHANGE TO FORMULARY		
2811	NON-FORMULARY DRUG UNDER CURRENT DSS THRESHOLD; WE ENCOURAGE PROVIDER TO CONTAC		
2812	CO-PAY ONLY CLAIM GREATER THAN $5.35 NOT ALLOWED		
2813	SAGA CLAIMS NOT COVERED PRIOR TO 02/01//08		
2814	CO-PAY ONLY CLAIM GREATER THAN $5.60 NOT ALLOWED		
2815	CHARTER OAK CLAIMS NOT COVERED PRIOR TO 08/01/2008		
2816	CO-PAY ONLY CLAIM GREATER THAN $6.00 NOT ALLOWED		
2817	MED D NF DRUG - CONTACT MD TO INITIATE PA FROM PDP OR CHANGE TO PDP FORMULARY D		
2818	CO-PAY ONLY CLAIM GREATER THAN $6.30 NOT ALLOWED		
2819	TB DIAGNOSIS CODE REQUIRED		
2820	CO-PAY ONLY CLAIM GREATER THAN $6.50 NOT ALLOWED		
2821	CO-PAY ONLY CLAIM GREATER THAN $6.60 NOT ALLOWED		
3000	Prior authorization services are exhausted.	198	CO
3002	NDC REQUIRES PRIOR AUTHORIZATION	197	CO
3003	Prior authorization is required for payment of this service.	197	CO
3004	Inpatient claim requires prior authorization	197	CO
3006	Prior authorization dollars are exhausted.	198	CO
3009	VO PA NOT ON FILE		
3010	Out of state non-emergency services require prior authorization.	197	CO
3011	PA REQUIRED FOR CDH INPATIENT STAY		
3015	CHC CARE PLAN REQUIRED	197	CO
3016	SERVICE NOT COVERED UNDER CHC CARE PLAN	197	CO
3019	Prior authorization cutback performed.	198	CO
3021	DRG requires prior authorization.	197	CO
3100	PA REQUIRED - DISPENSE THE GENERIC EQUIVALENT.	A1	CO
3101	PA REQUIRED, DISPENSE PREFERRED DRUG.	197	CO
3102	PA REQUIRED FOR PRESCRIPTIONS GREATER THAN $500.00.	15	CO
3103	DIAGNOSIS REQUIRES PRIOR AUTHORIZATION.	197	CO
3104	PA REQ ON NDC-CALL DSS 1-800-233-2503		
3105	NON-PREFERRED MH DRUG; CONTACT MD OR HP FOR PA		
3106	TRANSMUCOSAL FENTANYL REQUIRES PA FOR MORE THAN FOUR (4) DOSES PER DAY		

CDE_EOB	DSC_EOB	CDE_ADJ_RSN	CDE_GROUP
3107	NON-PREFERRED MH DRUG; DISPENSE PREFERRED BRAND	96	CO
3108	PA REQUIRED, DISPENSE PREFERRED BRAND.	165	CO
3300	EXCEEDS MAXIMUM REFILLS ALLOWED.	B5	CO
3301	OPTIMAL DOSAGE EXCEEDED.	119	CO
3302	THE NDC IS NOT CONSISTENT WITH THE BILLED DIAGNOSIS.	11	CO
3303	NDC IS NOT COVERED FOR THE CLIENT'S LIVING ARRANGEMENT.	A1	CO
3304	NDC IS LESS THAN EFFECTIVE/DESI DRUG.	A1	CO
3305	NO REIMBURSEMENT RULE FOR ASSOCIATED PATIENT RESIDENCE.	B18	CO
3306	CLAIM DETAIL EXCEEDS ALLOWABLE LIMIT. CONTACT THE PROVIDER ASSISTANCE CENTER.	A1	CO
3307	CLAIM NOT SUBMITTED WITH OUTER PACKAGE NDC.	125	CO
3308	DRUGS ARE INCLUDED IN THE NURSING HOME PER DIEM RATE.	97	CO
3309	NDC IS NOT COVERED FOR THE CLIENT'S PATIENT RESIDENCE.	A1	CO
3310	BILLED AMOUNT IS GREATER THAN ALLOWED AMOUNT - PRIOR AUTHORIZATION REQUIRED.	15	CO
3311	Claim dates of service overlap rate change. Rebill on two separate claims.	A1	CO
3312	Other insurance amount is greater than or equal to the allowed amount.	23	CO
3313	Freestanding alcohol clinic visits limited to 10 consecutive days.	119	CO
3314	HEADER DIAGNOSIS RESTRICTION FOR NDC UNDER PROVIDER CONTRACT.		
3315	ATP TABLE ERROR. CONTACT THE PROVIDER ASSISTANCE CENTER.	125	CO
3316	EXCEEDS THE MAXIMUM DAYS SUPPLY ALLOWED		
3317	INSTITUTIONAL NDC NOT COVERED		
3318	THE NDC IS NOT CONSISTENT WITH THE CLIENT'S GENDER		
3319	OTC DIABETIC TESTING SUPPLIES NOT PAYABLE UNDER PHARMACY POS FOR CLIENTS OVER T		
3325	LCA DETAIL DOS SPAN 2 PROVIDER TIERS		
3326	LCA DETAIL DOS SPAN 2 PROVIDER TIERS		
3600	Procedure billed by provider is not covered under the client's benefit plan.	B7	CO
4001	The diagnosis is not covered by this provider under the client's benefit plan.	96	CO
4002	NDC NOT PAYABLE FOR PROGRAM.	A1	CO
4004	NDC IS NOT ON FILE.	B18	CO
4007	NDC IS NOT COVERED DUE TO CMS TERMINATION.	96	CO
4009	PRICE VARIANCE SET - VERIFY UNITS/DOLLARS.	125	CO
4012	Claim denied after Medical Policy review.	95	CO
4013	Procedure code is not active for this date of service	B18	CO
4014	NO PRICING SEGMENT IS ON FILE.	B18	CO
4021	The procedure billed is not a covered service under the client's benefit plan.	96	CO
4022	Claim denied after Medical Policy review.	95	CO
4023	THE NDC IS NOT CONSISTENT WITH THE CLIENT'S GENDER.	7	CO
4025	THE NDC IS NOT CONSISTENT WITH THE CLIENT'S AGE.	6	CO
4026	QUANTITY DISPENSED EXCEEDS MAXIMUM ALLOWED.	119	CO
4030	THE DIAGNOSIS IS NOT CONSISTENT WITH THE CLIENT'S AGE.	9	CO
4031	The diagnosis is not consistent with the client's gender.	10	CO
4032	Procedure code is not on file.	B18	CO
4034	The service billed does not meet Connecticut Medicaid age criteria guidelines.	6	CO
4035	The procedure is not consistent with the client's gender.	7	CO
4036	Place of service is invalid for this procedure.	5	CO
4039	The primary diagnosis code is not covered.	146	CO
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.	146	CO
4041	Secondary diagnosis code not on file.	146	CO
4042	Third diagnosis code is not on file.	146	CO
4043	Fourth diagnosis code is not on file.	146	CO
4044	No reimbursement rule for associated client age	B18	CO
4045	Benefit plan restriction on reimbursement agreement.	96	CO
4046	PROCEDURE CODE BILLED PRIOR TO THE EFFECTIVE DATE	96	CO
4047	Fifth diagnosis code is not on file.	167	CO
4052	The admit diagnosis code is not on file.	146	CO
4053	Principal procedure code is not on file.	96	CO
4054	Second procedure code is not on file.	96	CO
4055	Third procedure code is not on file.	96	CO
4056	The fourth surgical procedure code is invalid.	B18	CO
4057	The fifth surgical procedure code is invalid.	B18	CO
4059	Revenue center code is not on file.	B18	CO
4061	NO REIMB RULE FOR ASSOCIATEDCLAIM TYPE		
4068	Service is not active on file on date of service.	96	CO
4070	MODIFIER RESTRICTION FOR PROCEDURE CODE		
4077	Revenue center code not active on file on date of service.	B18	CO
4093	Diagnosis is restricted under the client's benefit plan.	146	CO
4099	Diagnosis related group not on file.	96	CO
4113	UNIT DOSE PACKAGING NOT ALLOWED FOR A CLIENT WITH THIS PATIENT LOCATION		
4115	NO ANESTHESIA CONVERSION FACTOR ON FILE. CONTACT THE PROVIDER ASSISTANCE CENTER	B5	CO
4120	PROCEDURE CODE REQUIRES VALID QUADRANT		
4127	BENEFIT PLAN HIERARCHY IS NOT FOUND. CONTACT THE PROVIDER ASSISTANCE CENTER.	B5	CO
4130	PAYER HIERARCHY NOT FOUND. CONTACT THE PROVIDER ASSISTANCE CENTER.	B5	CO
4131	NO BENEFIT PLAN ASSOCIATED TO PAYER. CONTACT THE PROVIDER ASSISTANCE CENTER.	B5	CO

CDE_EOB	DSC_EOB	CDE_ADJ_RSN	CDE_GROUP
4132	DRG grouper is unable to assign DRG for pricing.	96	CO
4138	BILLING PROVIDER TYPE/SPECIALTY IS RESTRICTED FOR THE NDC UNDER THE CLIENT'S BE	B7	CO
4139	PERFORMING PROVIDER TYPE/SPECIALTY IS RESTRICTED FOR THE NDC UNDER THE CLIENT'S		
4140	The service submitted is not covered under the client's benefit plan.	96	CO
4142	Provider cannot bill this RCC according to the client's benefit plan.	172	CO
4148	PERFORMING PROVIDER TYPE/SPECIALTY IS RESTRICTED FOR THE NDC UNDER PROVIDER CON		
4149	Billing provider not authorized to bill for submitted procedure code.	172	CO
4151	Billing provider not authorized to bill for submitted service for client.	172	CO
4153	NDC CODE IS UNDER MEDICAL REVIEW FOR THIS PROVIDER CONTRACT		
4155	No reimbursement rule for the associated facility type	96	CO
4156	NO RELATIVE VALUE ON FILE FOR ANESTHESIA PROCEDURE. CONTACT THE PROVIDER ASSIST	B5	CO
4160	PROVIDER CONTRACT RESTRICTION FOR NDC UNDER PROVIDER CONTRACT.		
4161	Procedure code is restricted under provider's contract.	172	CO
4162	Revenue center code is restricted under provider's contract.	172	CO
4164	NDC IS INACTIVE.	B18	CO
4165	Exceeds the allowed days supply.	B5	CO
4182	The ICD-9 procedure is not consistent with the client's gender.	7	CO
4200	Zero allowed amount. Contact the Provider Assistance Center.	96	CO
4206	Quantity is restricted for procedure under provider contract.	96	CO
4207	CLIA certification not on file for billed dates of service.	17	CO
4208	CLIA laboratory procedure requires a modifier.	4	CO
4209	Procedure/modifier combination is not active on file on date of service.	B18	CO
4211	Tooth number is non-covered for the procedure code billed.	96	CO
4212	Services not covered by CLIA certificate.		
4219	Type of bill restriction under reimbursement agreement.	16	CO
4222	NDC CODE IS UNDER MEDICAL REVIEW FOR THIS BENEFIT PLAN		
4223	This procedure was denied after DSS review.	17	CO
4224	Quantity limit exceeded.	119	CO
4227	The RCC billed is not a covered service under the client's benefit plan.	96	CO
4229	This diagnosis was denied after DSS review.	17	CO
4240	Only one date of service allowed per detail.	119	CO
4244	Diagnosis is not covered under the client's benefit plan.	96	CO
4245	Fourth modifier invalid for the date of service.	B18	CO
4248	Procedure code requires a modifier.	4	CO
4249	MODIFIER REQUIRED OR NOT ALLOWED FOR PROVIDER TYPE AND SPECIALTY	4	CO
4250	No reimbursement rule for the associated provider type/provider specialty	B18	CO
4254	PATIENT RESIDENCE RESTRICTION FOR NDC ON PROVIDER CONTRACT		
4256	PRIMARY DIAGNOSIS RESTRICTION FOR THE NDC UNDER PROVIDER CONTRACT		
4257	SECONDARY DIAGNOSIS RESTRICTION FOR THE NDC UNDER BENEFIT PLAN		
4258	SECONDARY DIAGNOSIS RESTRICTION FOR THE NDC UNDER PROVIDER CONTRACT		
4259	The revenue center code is not consistent with the client's age.	6	CO
4260	PATIENT REASON FOR VISIT NOT ON FILE		
4271	Modifier conflict for procedure code under provider contract.	4	CO
4272	Procedure code and modifier combination is not valid for billing provider.	4	CO
4311	PRIMARY HEADER DIAGNOSIS RESTRICTION FOR PROCEDURE CODE UNDER PROVIDER CONTRACT	167	CO
4321	PRIMARY HDR DIAG RESTRICTION FOR BILLED REV CDE		
4350	Referring provider is not eligible to refer the service billed.	183	CO
4361	THE NDC BILLED REQUIRES A DIAGNOSIS CODE.	17	CO
4371	THIS TYPE OF CLAIM IS NOT COVERED UNDER THE CLIENT'S BENEFIT PLAN.	96	CO
4372	SECONDARY HEADER DIAGNOSIS RESTRICTION FOR PROCEDURE CODE UNDER PROVIDER CONTRA		
4373	CLAIM TYPE RESTRICTION FOR NDC UNDER BENEFIT PLAN		
4374	Revenue center code is not billable.	96	CO
4713	AGE RESTRICTION FOR THE NDC UNDER THE PROVIDER CONTRACT		
4714	Service billed does not meet age criteria according to the provider's contract.	6	CO
4715	This revenue center code is not consistent with the client's age.	6	CO
4731	ANY DTL DIAG RESTRICTION FOR COVERED PROC		
4733	Diagnosis is restricted for revenue center code under client's benefit plan.	146	CO
4736	The revenue center code is not consistent with the billed diagnosis.	11	CO
4742	The procedure is not consistent with the header diagnosis.	11	CO
4743	The procedure is not consistent with the detail diagnosis.	11	CO
4744	SECONDARY HEADER DIAGNOSIS RESTRICTION FOR THE PROCEDURE CODE UNDER BENEFIT PLA		
4766	The ICD-9 procedure is not consistent with the client's gender.	6	CO
4775	BILLING PROVIDER NOT AUTHORIZED TO BILL FOR SUBMITTED NATIONAL DRUG CODE.	172	CO
4801	PROCEDURE NOT COVERED. CHECK: PRIOR AUTHORIZATION, FTC, REFERRING PROVIDER, QU	170	CO
4803	NDC IS NOT BILLABLE UNDER PROVIDER CONTRACT.	B18	CO
4804	Revenue center code is not billable under provider contract.	96	CO
4821	Facility type is restricted for procedure under provider contract.	16	CO
4831	Service is not payable on date of service.	96	CO
4871	Invalid claim type for procedure code submitted.	96	CO
4873	Invalid claim type for National Drug Code submitted.	96	CO
4874	Invalid claim type for revenue center code submitted.	96	CO
4954	SERVICE RESTRICTION FOR PROCEDURE UNDER BENEFIT PLAN		

CDE_EOB	DSC_EOB	CDE_ADJ_RSN	CDE_GROUP
4955	SERVICE RESTRICTION FOR PROCEDURE UNDER REIMBURSEMENT.		
4956	SERVICE RESTRICTION FOR PROCEDURE UNDER PROVIDER CONTRACT.		
4957	SERVICE RESTRICTION FOR REVENUE UNDER BENEFIT PLAN.		
4958	SERVICE RESTRICTION FOR REVENUE UNDER REIMBURSEMENT.		
4959	SERVICE RESTRICTION FOR REVENUE UNDER PROVIDER CONTRACT		
4960	BENEFIT PLAN RESTRICTION FOR NDC UNDER BENEFIT PLAN		
4962	GENDER RESTRICTION FOR NDC UNDER PROVIDER CONTRACT.	7	CO
4963	Gender is restricted for procedure code under provider contract.	7	CO
4965	BENEFIT PLAN RESTRICTION FOR NDC UNDER PROVIDER CONTRACT		
4967	The revenue center code is not consistent with the client's gender.	7	CO
4970	THE REVENUE CENTER CODE BILLED IS RESTRICTED UNDER THE CLIENT'S BENEFIT PLAN.	96	CO
4975	The revenue center code billed is restricted under the provider's contract.	96	CO
4980	The procedure billed is restricted under the client's benefit plan.	96	CO
4984	PROCEDURE RESTRICTION FOR RCC UNDER BENEFIT PLAN.	172	CO
4985	PROCEDURE RESTRICTION FOR RCC UNDER PROVIDER CONTRACT.	172	CO
4986	PROCEDURE RESTRICTION FOR RCC UNDER REIMBURSEMENT AGREEMENT.	172	CO
5000	POSSIBLE DUPLICATE OF A PAID CLAIM OR A CLAIM THAT IS CURRENTLY IN PROCESS.	18	OA
5001	EXACT DUPLICATE OF A PAID CLAIM OR A CLAIM THAT IS CURRENTLY IN PROCESS.	18	OA
5007	EXACT DUPLICATE - HEADER OF A PAID CLAIM OR A CLAIM THAT IS CURRENTLY IN PROCES	18	OA
5008	Duplicate of a paid claim or a claim that is currently in process.	18	OA
5010	EXACT DUPLICATE DENTAL CLAIM OF A PAID OR PENDING CLAIM.	18	OA
5011	Duplicate tooth surface or billing provider of a paid or pending claim.	18	OA
5016	HOSPICE DUPLICATE		
5017	DUPLICATE, SERVICE PD TO NH OR HOSPICE		
5020	Duplicate coinsurance billed.	18	OA
5021	Duplicate coinsurance billed.	18	OA
5022	Duplicate coinsurance billed.	18	OA
5052	ENCOUNTER DUPLICATE MCO ICN		
5150	This service is limited to once in a client's lifetime.	35	CO
5151	UNITS EXCEED FREQUENCY UNITS ON CHC CARE PLAN	198	CO
5200	Psychotherapy w/evaluation and pharmacological mgmt not covered on same DOS.	97	CO
5202	Behavioral health and substance abuse intensive OP not covered on the same DOS.	97	CO
5203	Behavioral health and psychiatric intensive outpatient not covered on same DOS.	97	CO
5204	Behavioral health and day treatment not covered on the same date of service.	97	CO
5205	Skilled nursing and prenatal services are not covered on the same DOS.	97	CO
5206	Duplicate of a service paid.	18	OA
5207	Duplicate of a service paid.	18	OA
5208	Duplicate of a service paid.	18	OA
5209	DUPLICATE OF A SERVICE PAID.	18	OA
5210	Service previously paid under another procedure code.	18	OA
5211	Duplicate dental service.	18	OA
5212	Duplicate alveoloplasty service.	18	OA
5213	Pharmacological management and E&M codes not covered on the same DOS.	97	CO
5214	Demo and congregate services not covered on the same date of service.	97	CO
5215	Congregate and demo services not covered on the same date of service.	97	CO
5216	Medication code and intensive OP/day treatments not covered on the same DOS.	97	CO
5217	PERSONAL SUPPORT AND SUPPORTED LIVING/RES HABILITATION NOT COVERED ON SAME DOS.	97	CO
5218	ALS and ground mileage not covered on the same date of service.	97	CO
5219	TORCH panels and components are not covered on the same date of service.	97	CO
5221	General health panel and panel components are not covered on the same DOS.	97	CO
5224	Comprehensive metabolic panel and other panels are not covered on the same DOS.	97	CO
5225	Lipid panel and component are not covered on the same date of service.	97	CO
5226	Electrolyte and components are not covered on the same date of service.	97	CO
5227	Acute hepatitis and components are not covered on the same date of service.	97	CO
5230	Renal panel and other panels are not covered on the same date of service.	97	CO
5237	Hepatic panel and component are not covered on the same date of service.	97	CO
5242	Health & behavior assessments not covered on same DOS as psychiatry/eval mgmt.	97	CO
5244	Only one antepartum care code allowed per pregnancy.	35	CO
5245	Refitting/reconditioning is not covered same date of service as other services.	97	CO
5246	Independent living skill/group & ind not covered same DOS day habilitation.	97	CO
5247	Family training/day habilitation not covered on same DOS cognitive service.	97	CO
5248	Supported employment not covered same date of service pre-vocational services.	97	CO
5249	Day rehab/sub abuse/per hour not covered same DOS sub abuse/per day.	97	CO
5250	Transitional living service not covered same date of service as other services.	97	CO
5251	Refractive exam not covered same date of service as complete eye exam.	97	CO
5253	Stationary gas system and liquid oxygen system not covered within 28 days.	97	CO
5254	Stationary liquid system and portable system not covered within 28 days.	97	CO
5255	Habilitative services limited to one per date of service.	119	CO
5256	ADP/MR waiver services and CHC/CBS waiver services not covered on same DOS.	97	CO
5257	Complete screenings and partial screenings are not covered on the same DOS.	97	CO
5258	Complete screenings and partial screenings not covered on the same DOS.	97	CO
5259	Complete HH screenings and partial HH screenings are not covered on same DOS.	97	CO

CDE_EOB	DSC_EOB	CDE_ADJ_RSN	CDE_GROUP
5260	Clinic visits and EPSDT screenings are not covered on the same date of service.	97	CO
5261	Surgical procedures and est patient office visit not covered on the same DOS.	97	CO
5262	Payment for surgical procedure includes follow up hospital care.	97	CO
5263	PRIMARY SURGERY MUST BE PAID BEFORE MULTIPLE ADDITIONAL SURGERY CAN BE PAID	45	CO
5264	Only one new exam allowed every 3 years per provider per client.	119	CO
5267	Global delivery and separate del/antepartum within 180 days are not covered.	97	CO
5268	Postpartum service not covered within 60 days of global delivery service.	97	CO
5269	GLOBAL DELIVERY OR C-SECTION NOT ALLOWED IF SEPARATE BILLED.	97	CO
5270	TCM-DMR or CHC and DMH services are not covered on the same date of service.	97	CO
5271	HCBS/MR and ADP/MR services are not covered on the same date of service.	97	CO
5272	CHC/CBS and ADP/MR services are not covered on the same date of service.	97	CO
5274	Professional service and non emerg visit in ER/clinic not covered on same DOS.	97	CO
5275	CHC and TCM-DMR services are not covered on the same date of service.	97	CO
5276	Skilled nursing and prenatal services are not covered on the same DOS.	97	CO
5277	Surgical visit and abortion or other procedure are not covered on the same DOS.	97	CO
5278	Lens replacement service and frame/lens services are not covered on same DOS.	97	CO
5279	Neuropsychological eval and psychodiagnostic tests not covered within 365 days.	119	CO
5280	Global delivery and separate delivery/Cesarian cannot be billed separately.	97	CO
5282	Fitting of prosthesis and lens/frame service not covered on the same DOS.	97	CO
5284	Client frame service and other lens/frame service not covered on the same DOS.	97	CO
5285	Frame replacement service and frame/lens service not allowed on the same DOS.	97	CO
5286	Brainstem invoked response and CAT scan not covered within 3 months.	B5	CO
5287	Routine newborn care and critical care are not allowed on the same DOS.	97	CO
5289	Laboratory test included in office visit.	97	CO
5291	New PT visit not payable within three years of an established patient visit.	B5	CO
5292	CANNOT HAVE MULTIPLE PRIMARY SURGICAL PROCEDURES ON SAME DATE OFSERVICE.	B5	CO
5296	PRIMARY ANESTHESIA MUST BE PAID FIRST	45	CO
5298	Periodic exam is not covered within 6 months of initial exam.	119	CO
5299	Single first periapical and bitewing/panoramic not covered on the same DOS.	97	CO
5300	Office visit/consultation and radiology exam are not covered on the same DOS.	97	CO
5301	Only one new exam allowed every 3 years per provider per client.	119	CO
5303	Partial dentures are not covered after placement of full upper/lower dentures.	B5	CO
5304	Home Health visit and CHC screen are not covered on the same date of service.	97	CO
5305	Our records indicate that this tooth has already been extracted.	18	OA
5306	Intraoral and panoramic x-rays are not covered within 24 months of each other.	97	CO
5307	First periapical and bitewing/panoramic film are not covered on the same DOS.	97	CO
5308	Alveolar surgery and extractions are not covered on the same date of service.	97	CO
5309	Intraoral/panoramic and bitewing service are not covered on the same DOS.	97	CO
5310	Comprehensive exam and limited exam are not covered on the same DOS.	97	CO
5313	Ophthalmology procedure and office visit not covered on the same DOS.	97	CO
5314	Laboratory test included in office visit.	97	CO
5316	Duplicate dermatology services are not covered.	18	OA
5317	Xrays are included in the procedure.	97	CO
5318	Anesthesia services are not covered.	B7	CO
5319	PA required for > 1 physical therapy evaluation or check-up in 90 days.	197	CO
5320	PA required for > 1 occupational therapy evaluation or check-up in 90 days.	197	CO
5321	PA required for more than one hearing evaluation or check-up in 90 days.	197	CO
5324	Orthodontic screening and provider screening not allowed by the same provider.	49	CO
5325	Neuropsychological eval and psychiatric evaluation not covered within 365 days.	97	CO
5327	CHC health screen and clinic visit are not covered on the same date of service.	97	CO
5328	CHC health screen and routine service are not covered on the same DOS.	97	CO
5331	Basic panel and general health or comp panel not covered on the same DOS.	97	CO
5332	Electrolyte panel and basic metabolic panel not covered on the same DOS.	97	CO
5334	Partial dentures are not covered after placement of full upper/lower dentures.	B5	CO
5335	Office visit and surgery are not covered on the same date of service.	97	CO
5336	Duplicate dental procedure.	18	OA
5337	Outpatient psychiatric services not covered same day as psych/partial hospital.	97	CO
5338	OP psychiatric service not covered within 2 days of psych/partial hosp stay.	97	CO
5340	PA required for > 1 speech and language evaluation or check-up in 90 days.	197	CO
5342	PA required for > 1 speech and hearing evaluation or check-up in 90 days.	197	CO
5343	Dental screenings and orthodontic consults not covered for the same provider.	49	CO
5344	Dental screening and orthodontic screening are not covered on the same DOS.	97	CO
5345	Home health and CHC services are not covered on the same date of service.	97	CO
5346	Mileage is not payable for multiple patient ambulance trips.	96	CO
5399	HOSPICE - OTHER COVERED ONLY ON THE SAME DATE OF SERVICE AS EITHER ROUTINE HOSP		
5400	ASSERTIVE COMMUNITY TREATMENT AND RECOVERY ASSISTANT IS NOT COVERED ON THE SAM	B1	CO
5401	ASSERTIVE COMMUNITY TREATMENT AND PEER SUPPORTS IS NOT COVERED ON THE SAME DATE	B1	CO
5402	ONLY 1 HOSPICE LEVEL OF CARE ALLOWED PER DATE	B1	CO
5403	TRANSITIONAL CASE MANAGEMENT NOT COVERED SAME DATE OF SERVICE AS TARGETED CASE	B1	CO
5404	ASSERTIVE COMMUNITY TREATMENT AND COMMUNITY SUPPORT IS NOT COVERED ON THE SAME	B1	CO
5405	ASSISTIVE LISTENING DEVICE NOT COVERED WITHIN THREE YEARS OF HEARING AID		
5406	MEDICAL ABORTION PROCEDURE INCLUDES ALL ASSOCIATED SERVICES (HCG, ULTRASOUND, P		

CDE_EOB	DSC_EOB	CDE_ADJ_RSN	CDE_GROUP
5407	CDT CODE NOT BILLABLE SAME DATE OF SERVICE AS SIMILAR CPT CODE		
5434	SEDATIVE FILLING NOT COVERED FOLLOWING ENDODONTIC PROCEDURE ON SAME TOOTH.		
5435	CONSULATION MAY NOT BE BILLED WITH OTHER DIAGNOSTIC CODES		
5436	A BRIEF OFFICE VISIT FOR DRUG PRESCRIPTIONS USED IN TREATMENT OF MENTAL PSYCHON		
5437	ADJMENT OF GASTRIC BAND DIAMETER IS NOT PAYABLE WITHIN 90 DAYS OF A GASTRIC RES		
5439	INTERPRETATION OF PSYCH/OTHER MEDICAL EXAMS ON SAME DATE DEVELOPMENTAL OR NEURO		
5440	PSYCHIATRIC DIAGNOSTIC INTERVIEW NOT COVERED SAME DATE AS DEVELOPMENTAL /NEURO		
5441	A PSYCHIATRIC DIAGNOSTIC INTERVIEW (INCLUDING INTERACTIVE) IS NOT COVERED ON TH		
5442	PSYCHOLOGICAL TESTING IS NOT COVERED ON THE SAME DATE OF SERVICE AS DEVELOPMEN		
5443	LIMITED DEVELOPMENTAL TESTING IS NOT COVERED ON THE SAME DATE OF SERVICE AS PSY		
5444	EXTENDED DEVELOPMENTAL TESTING IS NOT COVERED ON THE SAME DATE OF SERVICE AS PS		
5445	NEUROPSYCHOLOGICAL TEST NOT COVERED SAME DAY AS PSYCHOLOGICAL/LIMITED/EXTENDED		
5511	SUSPECT DUPLICATE OF A LAB SERVICE		
5512	SUSPECT DUPLICATE OF AN AMBULATORY SURGICAL CENTER PROCEDURE		
5520	PROC CODE COMBO REDUCED TO MAX ALLOWED $49.97 OR DENIED BECAUSE BILLED WITHOUT	119	CO
5521	PROC CODE COMBO REDUCED TO MAX ALLOWED $47.47 OR DENIED BECAUSE BILLED WITHOUT	119	CO
5522	PROC CODE COMBO REDUCED TO MAX ALLOWED $64.52 OR DENIED BECAUSE BILLED WITHOUT	119	CO
5523	PROC CODE COMBO REDUCED TO MAX ALLOWED $61.29 OR DENIED BECAUSE BILLED WITHOUT	119	CO
5524	PROC CODE COMBO REDUCED TO MAX ALLOWED $47.82 OR DENIED BECAUSE BILLED WITHOUT	119	CO
5525	PROC CODE COMBO REDUCED TO MAX ALLOWED $55.07 OR DENIED BECAUSE BILLED WITHOUT	119	CO
5526	PROC CODE COMBO REDUCED TO MAX ALLOWED $61.19 OR DENIED BECAUSE BILLED WITHOUT	119	CO
5527	PROC CODE COMBO REDUCED TO MAX ALLOWED $72.43 OR DENIED BECAUSE BILLED WITHOUT	119	CO
5528	PROC CODE COMBO REDUCED TO MAX ALLOWED $68.81 OR DENIED BECAUSE BILLED WITHOUT	119	CO
5529	PROC CODE COMBO REDUCED TO MAX ALLOWED $93.76 OR DENIED BECAUSE BILLED WITHOUT	119	CO
5530	PROC CODE COMBO REDUCED TO MAX ALLOWED $89.07 OR DENIED BECAUSE BILLED WITHOUT	119	CO
5531	PROC CODE COMBO REDUCED TO MAX ALLOWED $70.02 OR DENIED BECAUSE BILLED WITHOUT	119	CO
5532	PROC CODE COMBO REDUCED TO MAX ALLOWED $77.13 OR DENIED BECAUSE BILLED WITHOUT	119	CO
5533	PROC CODE COMBO REDUCED TO MAX ALLOWED $85.70 OR DENIED BECAUSE BILLED WITHOUT	119	CO
5534	PROC CODE COMBO REDUCED TO MAX ALLOWED $102.61 OR DENIED BECAUSE BILLED WITHOU	119	CO
5535	PROC CODE COMBO REDUCED TO MAX ALLOWED $97.48 OR DENIED BECAUSE BILLED WITHOUT	119	CO
5536	PROC CODE COMBO REDUCED TO MAX ALLOWED $128.21 OR DENIED BECAUSE BILLED WITHOU	119	CO
5537	PROC CODE COMBO REDUCED TO MAX ALLOWED $121.80 OR DENIED BECAUSE BILLED WITHOU	119	CO
5538	PROC CODE COMBO REDUCED TO MAX ALLOWED $117.87 OR DENIED BECAUSE BILLED WITHOU	119	CO
5539	PROC CODE COMBO REDUCED TO MAX ALLOWED $130.97 OR DENIED BECAUSE BILLED WITHOU	119	CO
5550	OP detox not covered on same or overlapping dates as inpatient services.	97	CO
5551	Services not covered on same/overlapping dates of service as inpatient stays.	97	CO
5552	Service not covered on same/overlapping date of service as nursing home stay.	97	CO
5553	Rental not covered after purchase.	96	CO
5650	REPRICED DUE TO MULTIPLE SURGERY PRICING METHODOLOGY.	59	CO
5924	CLAIM DENIED, CCI GREATER AND LESSER PROCEDURES ARE NOT COVERED ON SAME DATE O	97	CO
5925	CCI COLUMN 1 CODE OR MUTUALLY EXCLUSIVE CODE WAS BILLED ON THE SAME DATE AS PRE	97	CO
5926	CCI COLUMN 2 CODE WAS BILLED ON THE SAME DATE AS PREVIOUS COLUMN 1 OR MUTUALLY	97	CO
5950	HOSPITAL RESERVE CANNOT EXCEED 15 DAYS/ DISCHARGE	125	CO
6000	CLAIM WAS MANUALLY PRICED OR DENIED FOR MISSING INFORMATION.	B5	CO
6001	End stage renal disease daily codes limited to one per day.	B14	CO
6002	End stage renal disease daily codes limited to one per day.	B14	CO
6003	Personal services are limited to one per day.	35	CO
6004	PA required for more than 14 dialysis treatments per calendar month.	197	CO
6005	End stage renal disease monthly codes are limited to one per month.	119	CO
6006	Only 96 Personal Care Assistance units allowed per date of service.	119	CO
6007	Prior authorization required for more than 1 evaluation per calendar year.	197	CO
6008	Personal response system limited to two per month.	119	CO
6009	Substance abuse program limited to 56 days per year.	119	CO
6010	ABI procedure exceeded $10,000 per year maximum.	119	CO
6012	ABI services limited to 40 hours per week.	119	CO
6013	Purchase of feeding pump is limited to one per three years.	119	CO
6014	Purchase of feeding tubes are limited to one per day.	119	CO
6015	Limit of one infusion pump per calendar month.	119	CO
6016	Purchase of parenteral infusion pumps are limited to one per three years.	119	CO
6017	PA required for rental after 3 months of continuous rental by same provider.	197	CO
6018	Only one enteral feeding or parenteral nutrition supply kit per day.	119	CO
6020	Transitional living services limited to 183 days per client lifetime.	35	CO
6021	PA required for more than 86 treatment services per calendar month.	197	CO
6022	PA required for more than 90 treatments per calendar year with diagnosis.	197	CO
6023	Purchase of IV poles is limited to 3 per year.	119	CO
6024	PA required for more than 1 evaluation in 365 days.	197	CO
6026	1 initial pers service allowed per client per billing and performing provider.	B5	CO
6027	CHC mental health counseling limited to 1 per provider/client/date of service.	119	CO
6028	Meal service limited to 1 per date of service.	119	CO
6029	Only 1 pers service allowed per calendar month.	119	CO
6030	MAXIMUM OF 25 HOURS OF NUTRITIONAL COUNSELING PER 365 DAYS		
6032	PA required for more than 5 occupational therapy visits per month.	197	CO

CDE_EOB	DSC_EOB	CDE_ADJ_RSN	CDE_GROUP
6033	PA required for > 9 occupational therapy visits per cal year with diagnosis.	197	CO
6034	PA required for more than 10 speech therapy visits per month.	197	CO
6035	PA required for more than 9 speech therapy visits per cal year with diagnosis.	197	CO
6036	PA required for more than 10 hearing therapy visits per month.	197	CO
6037	PA required for more than 9 hearing therapy visits per cal year with diagnosis.	197	CO
6040	Adult day care services are limited to one per day.	119	CO
6041	Adult day care services are limited to one per day.	119	CO
6042	Homemaker services limited to 96 units per date of service.	119	CO
6043	Homemaker services limited to 96 units per date of service.	119	CO
6044	Only one primary care code per provider per client per date of service allowed.	B14	CO
6045	Only one primary care code per provider per client per date of service allowed.	B14	CO
6049	Exceeds maximum of 9 screens per client age 5 - 21.	35	CO
6050	Exceeds maximum of 9 clinic screens per client age 5 - 21.	35	CO
6051	Exceeds maximum of 9 home health screens per client age 5 - 21.	35	CO
6052	Only 3 developmental screens per client per provider per 365 days.	119	CO
6053	Exceeds maximum of 11 screens per client age 0 - 4.	35	CO
6054	Exceeds maximum of 11 clinic screens per client age 0 - 4.	35	CO
6055	Exceeds maximum of 11 home health screens per client age 0 - 4.	35	CO
6056	PA required for more than 13 individual therapy visits in 90 days.	197	CO
6057	Environmental adaptations limited to $30,000 per calendar year.	119	CO
6058	Only two units of equipment allowed per calendar year.	119	CO
6059	ONLY 3 HEARINGS PER CLIENT PER PROVIDER PER YEAR.	119	CO
6062	ONLY 3 INTERPERIOD VISION PER CLIENT PER PROVIDER PER YEAR.	119	CO
6065	Only 90 days of facility based respite care per calendar year.	119	CO
6066	Only one respite service per month.	119	CO
6067	PA required for more than 13 group therapy visits in 90 days.	197	CO
6069	More than 1 unit per procedure per provider per client requires manual pricing.	45	CO
6071	Claim for assistant surgeon services was manually priced.	45	CO
6072	Only one new exam allowed every 3 years per provider per client.	119	CO
6073	Only 1 dental visit to a client in a nursing facility allowed per 365 days.	119	CO
6078	Exceeds limit of 9 screens allowed for ages 6 - 21.	119	CO
6079	Exceeds limit of 6 screens allowed for ages 2 - 6.	119	CO
6080	Exceeds limit of 5 screens allowed for ages 1 - 2.	119	CO
6081	Exceeds limit of 6 screens allowed for ages 0 - 1.	119	CO
6084	PA REQUIRED FOR MORE THAN 2 PHYSICAL THERAPY VISITS PER 7 DAYS.	197	CO
6085	PRIOR AUTHORIZATION REQUIRED FOR MORE THAN 1 CASE MANAGEMENT PER MONTH.	119	CO
6088	PA required for more than 13 family therapy visits in 90 days.	197	CO
6090	Surgical procedure with this place of service requires PA.	197	CO
6092	PA required for more than two clinic therapy services per calendar week.	197	CO
6093	PA required > 9 clinic therapy services per calendar year for diagnosis code.	197	CO
6094	PA required for more than two podiatry therapy services per calendar week.	197	CO
6095	PA required for more than 4 podiatry therapy services per calendar week.	197	CO
6096	PA required > 9 home health therapy services per cal year for diagnosis code.	197	CO
6097	PA required for > 2 Speech/Audiology therapy services per calendar week.	197	CO
6098	PA required for more than two therapy services per calendar week.	197	CO
6099	PA required for more than two visits per 365 days.	197	CO
6100	PA required > 9 podiatry therapy services per calendar year for diagnosis code.	197	CO
6101	PA required > 9 speech/audiology services per cal yr for diagnosis code.	197	CO
6102	Exceeds limit of one unit per date of service.	119	CO
6103	PA required for more than 1 clinic therapy service per calendar week.	197	CO
6104	Only 1 neuropsychological evaluation allowed per year.	119	CO
6105	PA required for fluoride treatment if 21 years or older.	197	CO
6106	PA required > 9 physical therapy visits per calendar year with diagnosis code.	197	CO
6107	PA required for > 90 treatment services per year with specific diagnosis.	197	CO
6108	Only 5 podiatry visits allowed per client per provider per calendar month.	119	CO
6109	PA is required for more than two visits per 365 days.	119	CO
6110	Only one panoramic x-ray is covered per 36 months.	119	CO
6112	PA required for more than 86 treatment services per calendar month.	197	CO
6113	ONLY ONE EXAMINATION CODE ALLOWED PER DAY		
6114	Only one CHC health screen can be performed on the same date of service.	119	CO
6115	Only one tooth sealant in 5 years per client and per tooth allowed.	119	CO
6116	Only one bitewing procedure allowed within a six month period.	119	CO
6117	Exceeds limit of one denture per 5 years.	119	CO
6118	Only one dental prophylaxis allowed per six months.	119	CO
6119	Only one periodic oral exam allowed per six months.	119	CO
6120	Only one initial oral exam allowed per 3 years.	119	CO
6121	Hearing test is only allowed when billed with hearing instrument.	B5	CO
6122	Records show that a fluoride treatment has been billed in the past 6 months.	119	CO
6123	Exceeds limit of one upper partial per 5 years.	119	CO
6124	Exceeds limit of one lower partial per 5 years.	119	CO
6126	Only one electromyography procedure allowed per date of service.	119	CO
6127	DME purchase limited to one per lifetime.	35	CO

CDE_EOB	DSC_EOB	CDE_ADJ_RSN	CDE_GROUP
6129	Space shoes are limited to 1 per 3 years.	119	CO
6131	Hepatitis B immunization limited to 3 times per lifetime.	35	CO
6133	PA required for more than 13 therapy services in 90 days.	119	CO
6134	PA required for more than 26 therapy services in 6 months.	119	CO
6135	Only one Nursing Home status review per 45 days.	119	CO
6138	More than one visit with client on the same date of service requires PA.	197	CO
6141	PA is required for more than 12 skilled nursing visits per month.	197	CO
6145	Exceeds limit of one per 2 years.	119	CO
6146	Meal service limited to 1 per date of service.	119	CO
6147	Only one pers service allowed per calendar month.	119	CO
6148	Only one restoration per tooth surface allowed per year.	119	CO
6149	Evaluations are limited to one per year.	119	CO
6150	Only 2 consultations are allowed per provider per client per year.	119	CO
6153	Psychological evaluations are limited to one per year.	119	CO
6155	PA required for more than one evaluation per year.	197	CO
6156	Exceeds maximum of one visit per week.	197	CO
6158	PA rquired for more than 12 nurse visits per month.	197	CO
6159	Home Health aide units exceed policy requirements.	197	CO
6160	PRIOR AUTHORIZATION REQUIRED MORE THAN 13 THERAPY SERVICES PER 90 DAYS	197	CO
6161	PRIOR AUTHORIZATION REQUIRED FOR MORE THAN 2 THERAPY VISITS PER WEEK	197	CO
6163	Only one skilled nursing evaluation allowed per year.	119	CO
6164	PA required for more than 13 therapy or child guidance visits in 90 days.	197	CO
6165	PA required for more than 26 therapy or child guidance visits in 6 months.	197	CO
6166	Only one clinic visit allowed per day per client per provider.	B14	CO
6168	Psychotherapy performed in SNF/ICF requires PA.	197	CO
6169	Mental health counseling limited to 1 per provider/client/date of service.	119	CO
6171	Respite care limited to 720 hours per 365 days.	119	CO
6172	Only one status review allowed per 30 days.	119	CO
6173	Only one joint or initial assessment per 60 days.	119	CO
6174	1 initial pers service allowed per client per billing and performing provider.	119	CO
6177	Only one orthodontic consult per client's lifetime.	35	CO
6178	Only one preliminary orthodontic assessment per client's lifetime.	35	CO
6179	End stage renal disease monthly codes are limited to one per month.	119	CO
6181	Only one visit per day per revenue center code is allowed.	B14	CO
6182	ICF/MR home reserve days billed exceeds the maximum of 36 days per year.	119	CO
6183	Home reserve days billed exceeds the maximum of 21 days per year.	119	CO
6184	Procedure requires prior authorization.	197	CO
6185	Procedure requires prior authorization.	197	CO
6186	Complex visit requires PA.	197	CO
6187	Only 3 units of non-sterile gloves allowed per day.	119	CO
6188	Only one DMH-TCM service allowed per calendar month.	119	CO
6189	Only one psychotherapy w/medical evaluation & management allowed per DOS.	119	CO
6190	Only one psychotherapy w/medical evaluation & management allowed per DOS.	119	CO
6191	ONE PHARMACOLOGIC MANAGEMENT VISIT PER DAY.	119	CO
6193	Only one biopsy per day allowed.	119	CO
6194	Duplicate of a service paid	18	OA
6195	Duplicate of a service paid	18	OA
6196	Duplicate of a service paid	18	OA
6197	Duplicate of a service paid	18	OA
6198	Duplicate of a service paid	18	OA
6199	Duplicate of a service paid	18	OA
6200	Duplicate of a service paid	18	OA
6201	Duplicate of a service paid	18	OA
6202	Duplicate of a service paid	18	OA
6203	Duplicate of a service paid	18	OA
6204	Duplicate of a service paid	18	OA
6205	Duplicate of a service paid	18	OA
6206	Duplicate of a service paid	18	OA
6207	Duplicate of a service paid	18	OA
6208	Duplicate of a service paid	18	OA
6209	Duplicate of a service paid	18	OA
6210	Duplicate of a service paid	18	OA
6211	Duplicate of a service paid	18	OA
6212	Duplicate of a service paid	18	OA
6213	Duplicate of a service paid	18	OA
6214	Duplicate of a service paid	18	OA
6215	Duplicate of a service paid	18	OA
6216	Duplicate of a service paid	18	OA
6217	Duplicate of a service paid	18	OA
6218	Only one equipment service per calendar month.	119	CO
6219	Only one targeted case management service per calendar month.	119	CO
6220	Only one service bundle allowed per calendar month.	119	CO

CDE_EOB	DSC_EOB	CDE_ADJ_RSN	CDE_GROUP
6221	Only one evaluation allowed per calendar month.	119	CO
6222	PA required after 3 months of rental.	197	CO
6223	DME service with facility type code of 31 or 32 requires PA.	197	CO
6224	Medical management and psychotherapy not covered on the same date of service.	97	CO
6225	Complex visit requires PA.	197	CO
6226	Preventative counseling limited to one per day.	119	CO
6227	Preventative medicine counseling limited to one per day.	119	CO
6228	Audiologic function test limited to $115.12 per 365 days.	119	CO
6229	PA required for more than 2 nursing visits per week.	197	CO
6230	PLAN OF CARE EXCEEDED OR PA REQUIRED > 2 NURSE VISITS PER WEEK	197	CO
6231	PA required for > 2 services per year for Behavioral Health Partnership.	197	CO
6232	PA REQUIRED MORE THAN 12 SERVICES PER YEAR FOR BEHAVIORAL HEALTH PARTNERSHIP.	197	CO
6233	PA REQUIRED FOR MORE THAN 56 AIDE UNITS PER WEEK	197	CO
6234	PLAN OF CARE EXCEEDED OR PA REQUIRED > 56 UNITS PER WEEK		
6235	PLAN OF CARE EXCEEDED OR PA REQUIRED > 2 PT/ST VISITS PER WEEK		
6236	PLAN OF CARE EXCEEDED OR PA REQUIRED > 1 OT VISIT PER WEEK		
6400	TOTAL NON-MEDICAL TRANSPORTATION SERVICES LIMITED TO $1,000 PER CALENDAR YEAR.	119	CO
6401	PA REQUIRED FOR MORE THAN 2 PT VISITS PER WEEK		
6402	PA REQUIRED FOR MORE THAN 1 OT VISITS PER WEEK		
6403	PA REQUIRED FOR MORE THAN 9 OT VISITS PER CALENDAR YEAR FOR DIAGNOSIS		
6404	PA REQUIRED FOR MORE THAN 2 SPEECH THERAPY VISITS PER WEEK.		
6405	PA REQUIRED FOR MORE THAN 9 SPEECH THERAPY VISITS PER CALENDAR YEAR FOR DIAGNOS		
6406	PA REQUIRED FOR MORE THAN 2 AUDIOLOGY VISITS PER WEEK.		
6407	PA REQUIRED FOR MORE THAN 9 AUDIOLOGY VISITS PER CALENDAR YEAR WITH DIAGNOSIS.		
6408	2 CONSULTATIONS ARE ALLOWED PER YEAR PER PROVIDER		
6409	1 CONSULTATION ALLOWED PER 30 DAYS PER PROVIDER		
6410	PA REQUIRED FOR MORE THAN 5 DAYS OF GENERAL INPATIENT HOSPICE CARE IN A HOSPITA		
6411	ONLY 5 DAYS OF RESPITE CARE IN A NF OR HOSPITAL IS ALLOWED IN ANY 60 DAY PERIOD		
6412	PROCEDURE LIMITED TO ONCE PER LIFETIME PER TOOTH		
6413	PROCEDURE LIMITED TO THREE PER LIFETIME		
6414	TWO EYEGLASS LENSES PER 365 DAYS.		
6415	ONE EYEGLASS FRAME PER YEAR PER CLIENT		
6416	LIMIT THE REIMBURSEMENT FOR SPECTACLE FITTINGS TO ONE UNIT PER CLIENT PER 365 D		
6417	ASSISTIVE TECHN LIMITED TO $1000.00 PER YEAR		
6418	ONLY ONE UNIT OF TARGETED CASE MANAGEMENT ALLOWED PER WEEK EFFECTIVE 11/01/2010		
6419	PLAN OF CARE EXCEEDED OR PA REQUIRED > 56 UNITS PER WEEK		
6420	PLAN OF CARE EXCEEDED OR PA REQUIRED > 2 NURSE VISITS PER WEEK		
6422	ONLY ONE FAMILY PSYCHOTHERAPY PAYABLE PER DAY		
6423	ONLY ONE GROUP PSYCHOTHERAPY PAYABLE PER DAY		
6424	ONLY ONE INDIVIDUAL PSYCHOTHERAPY PAYABLE PER DAY		
6425	PERIODIC ORAL EVALUATION LIMITED TO ONCE PER 6 MONTHS FOR CLIENTS 20 AND UNDER		
6426	PERIODIC ORAL EVALUATION LIMITED TO ONCE PER 12 MONTHS FOR CLIENTS 21 AND OVER		
6427	COMPREHENSIVE ORAL EVALUATION LIMITED TO ONCE PER 3 YEARS WHEN UNDER 21		
6428	COMPREHENSIVE ORAL EVALUATION LIMITED TO ONCE CLIENT'S LIFETIME WHEN 21 AND OLD		
6429	1 BITEWING PROCEDURE ALLOWED PER SIX MONTHS FOR CLIENTS UNDER 21		
6430	4 PERIAPICAL RADIOGRAPHS ALLOWED PER 12 MONTHS FOR CLIENTS 21 AND OVER.		
6431	ONLY 1 BITEWING RADIOGRAPH ALLOWED PER YEAR FOR CLIENTS 21 AND OVER		
6432	ONLY 1 DENTAL PROPHYLAXIS ALLOWED PER YEAR FOR CLIENTS 21 AND OVER		
6433	ONLY 1 DENTAL PROPHYLAXIS ALLOWED PER SIX MONTHS FOR CLIENTS 20 AND UNDER.		
6434	EXCEEDS LIMIT OF ONE DENTURE PER 5 YEARS FOR CLIENTS UNDER 21		
6435	EXCEEDS LIMIT OF 1 DENTURE PER 7 YEARS FOR CLIENTS 21 AND OVER		
6436	1 UPPER PARTIAL PER 5 YEARS FOR CLIENTS UNDER 21		
6437	1 UPPER PARTIAL PER 7 YEARS FOR CLIENTS UNDER 21		
6438	1 LOWER PARTIAL PER 5 YEARS FOR CLIENTS UNDER 21		
6439	1 LOWER PARTIAL PER 7 YEARS FOR CLIENTS UNDER 21		
6440	SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES LIMITED TO $2,500.00 PER YEAR FOR ED		
6441	INDIVIDUAL GOODS AND SERVICES LIMITED TO $6,000.00 PER YEAR FOR EDS WAIVER.		
6442	HEARING AID COVERAGE LIMITED TO $1000 EVERY 24 MONTHS FOR HUSKY B CLIENTS		
6443	HUSKY B EYEGLASS/CONTACT COVERAGE LIMITED TO $100 EVERY 2 CALENDAR YEARS		
6444	HUSKY B NURSING HOME COVERAGE LIMITED TO 60 DAYS		
6445	CHOAK LIMITED TO ONE WELL VISIT PER YEAR		
6446	CHOAK LIMITED TO ONE EYE EXAM PER YEAR		
6447	QUANTITY LIMITATIONS PER CALENDAR MONTHS MED SURGE SUPPLIES - LIMIT OF 1		
6448	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 2		
6449	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 4		
6450	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 8		
6451	QUANTITY LIMITATION PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 16		
6452	QUANTITY LIMITATION PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 31		
6453	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 60		
6454	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 100		
6455	QUANTITY LIMITATION PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 150		
6456	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 200		

CDE_EOB	DSC_EOB	CDE_ADJ_RSN	CDE_GROUP
6457	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 250		
6458	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 300		
6459	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 500		
6460	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES LIMIT OF 2 WITH MODI		
6461	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES LIMIT OF 2 EXCLUDE M		
6462	QTY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLY LIMIT OF 1 QTY WITH MODIFIE		
6463	QTY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLY LIMIT OF 1 EXCLUDE MODIFIER		
6464	QTY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLY LIMIT OF 4 QTY WITH MODIFIE		
6465	QTY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLY LIMIT OF 4 QTY EXCLUDE MODI		
6466	LIVE-IN CAREGIVER SERVICE LIMITED TO $600.00 PER MONTH		
6467	QUANTITY LIMITATIONS PER CALENDAR MONTH MED SURGE SUPPLIES - LIMIT OF 20		
6468	TARGETED CASE MANAGEMENT IS A WEEKLY SERVICE		
6469	BIRTHING CENTER RCC LIMIT 1 PER PREGNANCY		
6470	RECORDS SHOW THAT A FLUORIDE TREATMENT HAS BEEN BILLED IN THE PAST 6 MONTHS.	119	CO
6471	1 BITEWING PROCEDURE ALLOWED PER SIX MONTHS FOR CLIENTS UNDER 21	119	CO
6472	PERIODIC ORAL EVALUATION LIMITED TO ONCE PER 6 MONTHS FOR CLIENTS 20 AND UNDER	119	CO
6473	ONLY 1 DENTAL PROPHYLAXIS ALLOWED PER SIX MONTHS FOR CLIENTS 20 AND UNDER.	119	CO
6477	QUANTITY LIMITATIONS PER 365 DAYS - PROSTHETIC SUPPLIES LIMIT OF TWO		
6480	CHOAK LIMITED TO ONE EYE EXAM PER YEAR	119	CO
6481	LIMIT OF 2 PAIRS OF SHOES PER CALENDAR YEAR		
6482	AUTISM SERVICE 1 UNIT PER MONTH		
6483	ASSISTIVE TECHNOLOGY LIMITED TO $5000 PER 5 YEARS		
6484	SPERMICIDE LIMIT TO 1 PER MONTH	119	CO
6485	FEMALE CONDOMS LIMITED TO 30 PER MONTH	119	CO
6486	MALE CONDOMS LIMITED TO 36 PER MONTH	119	CO
6487	AUDIOLOGY EVALUATION LIMIT TO 1 (4 UNITS) PER CALENDAR YEAR	119	CO
6488	PA REQUIRED FOR MORE THAN ONE AUDIOLOGY EVALUATION PER CALENDAR YEAR.	119	CO
6555	EXCEEDED ENTERAL QUANTITY.	B5	CO
6556	DURATION OF THERAPY EXCEEDED.	B5	CO
6557	CHARTER OAK PHARMACY BENEFIT EXCEEDED.		
6700	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED	119	CO
6701	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6702	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6703	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6704	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6705	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6706	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6707	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6708	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6709	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6710	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6711	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6712	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6713	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6714	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6715	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6716	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6717	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6718	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6719	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED		
6850	ONLY ONE INITIAL HOSPITAL VISIT ALLOWED PER ADMISSION.	119	CO
6851	INPATIENT RESERVE DAYS OVER 15 ARE NOT COVERED.	96	CO
6900	15 DAY LIMIT FOR ALCOHOL RELATED TREATMENT	B5	CO
6901	20 DAY LIMIT FOR DRUG RELATED TREATMENT.	B5	CO
6902	30 VISIT LIMIT FOR DRUG AND ALCOHOL RELATED SERVICES	B5	CO
6903	HOME HEALTH LIMIT TO 30 VISITS	B5	CO
6904	LIMIT MLIA CLIENTS TO 90 DAYS LONG TERM CARE CVRG PR ADM		
7000	CLAIM SET AN OVERRIDEABLE PRODUR ALERT.	B5	CO
7001	CLAIM GENERATED AN INFORMATIONAL PRODUR ALERT.	B5	CO
7002	DENIED FOR PRODUR REASONS.	B5	CO
7003	CLAIM GENERATED ALERT THAT REQUIRES PA.	B5	CO
7004	CLAIM DENIED FOR PRODUR ALERT.	B5	CO
7500	OUT OF STATE PROVIDER BILLING NON-XOVR DME SERVICE OR CLAIM DENIED AFTER DSS RE	17	CO
7503	MISSING/INVALID CONFLICT CODE. USE APPROPRIATE CODE AND RESUBMIT.	B5	CO
7504	MISSING/INVALID PRODUR INTERVENTION CODE.	B5	CO
7505	MISSING/INVALID PRODUR OUTCOME CODE.	B5	CO
7506	RESPONSE CLAIM. ORIGINAL CLAIM FAILED A NON-OVERRIDEABLE ALERT. PA REQUIRED.	B5	CO
7507	VALID OUTCOME CODE OF "NOT FILLED" RECEIVED. RESPONSE ACCEPTED, CLAIM REJECTED	B5	CO
7508	QUANTITY DISPENSED ON RESPONSE CLAIM SAME AS ORIGINAL CLAIM.	B5	CO
7510	RESUBMIT VIA PAPER CLAIM WITH PATHOLOGY REPORT ATTACHED.	B5	CO
7511	RESUBMIT VIA PAPER CLAIM WITH OPERATIVE REPORT ATTACHED.	B5	CO
7512	RESUBMIT VIA PAPER CLAIM WITH PRE-OP X-RAY.	B5	CO

CDE_EOB	DSC_EOB	CDE_ADJ_RSN	CDE_GROUP
7513	RESUBMIT VIA PAPER CLAIM WITH DESCRIPTION OF SERVICE.	B5	CO
7514	PRICE CANNOT BE ESTABLISHED DUE TO M/I REQUIRED DOCUMENTATION; PLEASE REMIT NEW	B5	CO
7515	MISMATCHED NDC/J-CODE COMBINATION; PLEASE CORRECT & RESUBMIT	B5	CO
7516	UNCLASSIFIED J-CODE MAY NOT BE SUBMITTED FOR NDC WITH A UNIQUE J-CODE	B5	CO
7517	PROFESSIONAL CLAIM SUBMITTED WITH NO NDC	B5	CO
7518	PROFESSIONAL CLAIM SUBMITTED WITH INVALID DOSE OR UNIT OF MEASURE	B5	CO
7519	THE CONSENT FORM HAS NOT YET BEEN RECEIVED	B5	CO
7520	THE CONSENT FORM IS INCOMPLETE	B5	CO
7521	THE STERILIZATION WAS NOT PERFORMED WITHIN 180 DAYS OF THE CLIENTS CONSENT	B5	CO
7522	THE STERILIZATION WAS PERFORMED BEFORE 30 DAY WAITING PERIOD ELAPSED	B5	CO
7523	DATE OF SERVICE ON CLAIM DOES NOT MATCH DATE OF SERVICE ON CONSENT FORM	B5	CO
7524	SIGNATURE DATE OF PERSON OBTAINING CONSENT <> CLIENTS SIGNATURE DATE	B5	CO
8135	CLAIM ADJUSTED DUE TO PATIENT LIABILITY CHANGE.	133	OA
8183	CLAIM WAS ADJUSTED DUE TO RETRO CLIENT DATE OF DEATH UPDATE.	13	OA
8186	CLAIM WAS ADJUSTED DUE TO A PROVIDER RATE CHANGE.	45	CO
8187	CLAIM WAS ADJUSTED DUE TO AN MSA RATE CHANGE.		
8188	PROVIDER RECOUPED CLAIM		
8200	CLAIM WAS ADJUSTED AS A RESULT OF A PAYMENT APPEAL	119	CO
8201	CLAIM WAS ADJUSTED AS A RESULT OF SAGA REPRICING	172	CO
8202	CLAIM HAS BEEN RECOUPED DUE TO TPL AUDIT FAILURE		
8203	HMS ADJUSTMENT		
8204	PARTIAL RECOUPMENT BY A PAID CLAIM ADJUSTMENT REQUEST		
8205	REQUESTED DATA UPDATED BY PAID CLAIM ADJUSTMENT REQUESTS		
8206	TPL - MEDICARE HOME HEALTH PROJECT FULL RECOUPMENT		
8207	TPL - MEDICARE HOME HEALTH PROJECT PARTIAL RECOUPMENT		
8230	HMS Medicare Part A/B Recovery	125	CO
8231	CLAIM RECOUPMENT DUE TO VOIDED PAYMENT.		
8232	CLAIM WAS ADJUSTED AS A RESULT OF A PROVIDER REFUND.	195	CO
8233	CLAIM WAS ADJUSTED AS A RESULT OF A PARTIAL PROVIDER REFUND		
8240	CLAIM WAS ADJUSTED DUE TO A RETRO ME UPDATE	172	CO
8241	CLAIM WAS HISTORY ADJUSTED DUE TO A RETRO ME UPDATE.	172	CO
8242	CLAIM WAS ADJUSTED DUE TO A RCC RATE CHANGE.		
8243	CLAIM WAS ADJUSTED DUE TO A RATE CHANGE.		
8244	CLAIM WAS ADJUSTED DUE TO A UCC RATE CHANGE.		
8245	CLAIM RECOUPED AS PART OF A SYSTEMATIC RECOUPMENT.		
8246	CLAIM WAS MASS ADJUSTED DUE TO A SPECIAL ALLOWED GREATER THAN BILLED MASS ADJUS		
8247	CLAIM ADJUSTED BY RETRO ME UPDATE. CLIENT NO LONGER RESPONSIBLE FOR COST SHARE		
8513	CLIENT LOCATION RESTRICTION.	58	CO
8515	THIS CLAIM HAS BEEN DENIED DUE TO A POS REVERSAL TRANSACTION.		
8700	LAB PROCEDURE NOT COVERED FOR OUTPATIENT CROSSOVER		
9000	THE SUBMITTED CHARGE EXCEEDS THE ALLOWED CHARGE.	172	CO
9001	REIMBURSEMENT REDUCED BY THE CLIENT'S CO-PAYMENT AMOUNT.	3	PR
9002	REFUND CO-PAY FROM ORIGINAL CLAIM TO CLIENT. CLIENT NO LONGER RESPONSIBLE FO	3	PR
9003	PAID AMOUNT REDUCED TO ZERO DUE TO TPL/PATIENT LIABILITY/APPLIED INCOME/RENT TO	142	PR
9004	CLAIM HAS BEEN RECOUPED DUE TO TPL AUDIT FAILURE		
9005	CLIENT RETROACTIVELY MEDICAID ELIGIBLE- REVERSE THEN REBILL PDP- BILL CO-PAY T	95	CO
9006	ANNUAL CH OAK RX BENEFIT MET. CLAIM ZERO PAID.		
9007	CLAIM REDUCED DUE TO ANNUAL CH OAK RX BENEFIT MET.		
9008	CLIENT NO LONGER RESPONSIBLE FOR COINSURANCE/DEDUCTIBLE/CO-PAY. REFUND ANY O		
9009	REIMBURSEMENT REDUCED BY PARTIAL CO-PAYMENT AMOUNT.	3	PR
9010	CLIENT EXEMPT FROM COPAY		
9011	OUT-OF-POCKET MAXIMUM COPAY MET		
9907	TPL AMOUNT APPLIED.	172	CO
9908	PRICING ADJUSTMENT - PHARMACY PRICING APPLIED.	172	CO
9910	PHARMACY DISPENSING FEE APPLIED.	172	CO
9916	PRICING ADJUSTMENT - UCC RATE PRICING APPLIED.	172	CO
9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	172	CO
9919	PRICING ADJUSTMENT - LONG TERM CARE PRICING APPLIED.	172	CO
9922	PATIENT LIABILITY, APPLIED INCOME OR SPENDDOWN AMOUNT APPLIED.	142	PR
9923	PAYMENT AMOUNT REDUCED BY CLIENT CONTRIBUTION	2	PR
9926	CLAIM HAS CUTBACK AMOUNT.	172	CO
9928	PRICING ADJUSTMENT - ANESTHESIA PRICING APPLIED.	172	CO
9929	PRICING ADJUSTMENT - LONG TERM CARE PRICING APPLIED USING MULTIPLE RATES.	172	CO
9930	PRICING ADJUSTMENT - LONG TERM CARE NON COVERED DAYS.	B1	CO
9931	PRICING ADJUSTMENT - LONG TERM CARE SERVICE NOT PAYABLE.	B18	CO
9934	PRICING ADJUSTEMENT - PAY UP TO MAX FEE PRICING APPLIED.	172	CO
9935	PRICING ADJUSTMENT - MAX FLAT FEE PRICING APPLIED	172	CO
9939	PRICING ADJUSTMENT - LESSER OF BILLING OR PERFORMING PROVIDER UCC.	172	CO
9960	PRICING ADJUSTMENT - PSYCHIATRIC HOSPITAL 30 PLUS DAY RATE APPLIED.	172	CO
9963	PRICING ADJUSTMENT - PHYSICIAN ASSISTANT PRICING APPLIED	172	CO
9964	PRICING ADJUSTMENT - ACA MAX FEE PRICING APPLIED	172	CO
9965	ACA ENHANCED RATE ADD ON	172	CO

CDE_EOB	DSC_EOB	CDE_ADJ_RSN	CDE_GROUP
9969	PCMH HEALTH CENTER		
9970	PRICING ADJUSTMENT - FULL LCA RATE APPLIED	172	CO
9971	PRICING ADJUSTMENT - PARTIAL OR NO LCA RATE APPLIED	172	CO
9972	PRICING ADJUSTMENT - PCMH PARTIAL OR NO PERCENT RATE APPLIED	172	CO
9973	PRICING ADJUSTMENT - PCMH PARTIAL OR NO FIXED AMT APPLIED	172	CO
9974	PRICING ADJUSTMENT - PCMH FIXED AMOUNT APPLIED	172	CO
9975	PRICING ADJUSTMENT - PCMH PERCENTAGE RATE APPLIED	172	CO
9976	PRICING ADJUSTMENT - METROPOLITAN STATISTICAL AREA PRICING APPLIED		
9977	PRICING ADJUSTMENT - PROVIDER RCC CUSTOMARY CHARGE PRICING APPLIED	172	CO
9978	PRICING ADJUSTMENT - DEFICIT REDUCTION ACT (DEFRA) PRICING APPLIED.	172	CO
9979	PRICING ADJUSTMENT - OUTPATIENT HOSPITAL LAB FEE PRICING APPLIED.	172	CO
9980	Ancillary services included in per diem rate.	97	CO
9981	REDUCED TO MAXIMUM ALLOWABLE		
9990	PRICED AFTER MANUAL REVIEW.	172	CO
9991	BILLED UNITS HAVE BEEN CUTBACK TO CONTRACT MAXIMUM		
9996	REFER TO HEADER EOB		
9997	REFER TO DETAIL EOB		
9998	REDUCED TO MAXIMUM ALLOWABLE.	172	CO