CDE_EOB	DSC_EOB
0	INACTIVE ERROR CODE. MODIFIED
1	INTERNAL EDIT.
2	PROCESSED IN ERROR. CLAIM WILL BE REPROCESSED.
3	CLAIM DENIED. FIX ERRORS AND RESUBMIT.
40	CLAIM PAID BEYOND TIMELY FILING LIMIT DUE TO SPECIAL HANDLING
84	PARTIAL RECOUPMENT.
91	REDUCED TO MAXIMUM ALLOWED ON PRIOR AUTHORIZATION FILE.
93	WE HAVE DEDUCTED THE ORIGINAL PAYMENT AS A RESULT OF A PAYMENT APPEAL.
94	PAYMENT AMOUNT REDUCED BY EXCESS ASSETS.
97	PAYMENT REDUCED BY OTHER INSURANCE/ADJUSTMENT TO PAYMENT AMOUNT.
100	REDUCE TO MAXIMUM ALLOWED ON PRIOR AUTHORIZATION FILE.
102	SERVICE IS NOT COVERED FOR ELIGIBILITY DETERMINATION.
107	PAID AMOUNT REDUCED BY OTHER INSURANCE AND COPAY.
108	PAID AMOUNT REDUCED TO ZERO BY OTHER INSURANCE AND COPAY.
109	AMOUNT REFLECTS MONIES RECOUPED FOR MEDICARE COVERED SERVICES.
111	MEDICARE RECONSIDERATION ADJUSTMENT.
113	CLAIM/DETAIL PAID USING FQHC PRICING.
131	PAYMENT AMOUNT REFLECTS COMPOSITE PANEL RATE.
135	DENIED. CLAIM CORRECTION FORM RESPONSE NOT RECEIVED OR INSUFFICIENT TO PROCESS.
137	HMS SPECIAL PROJECT RECOUPMENT-FULL.
157	NDC IS MISSING.
158	CLAIM/DETAIL PAID PARTIAL CO-INSURANCE AND DEDUCTIBLE BILLED.
159	CLAIM/DETAIL PAID PARTIAL DEDUCTIBLE BILLED.
161	CLAIM/DETAIL DENIED BY MEDICARE.
164	CLAIM/DETAIL PAID IN FULL BY MEDICARE.
165	MEDICARE PAYMENT IS EQUAL TO OR EXCEEDS MEDICAID ALLOWED CHARGE.
169	NO CO-INSURANCE OR DEDUCTIBLE DUE.
171	PAYMENT AMOUNT REDUCED BY APPLIED INCOME.
177	PAYMENT AMOUNT REFLECTS RENT TO PURCHASE PRICING.
188	THIS SAGA CLAIM HAS BEEN RECOUPED AND RESUBMITTED AS A MEDICAID CLAIM.
195	RETROACTIVE DATE OF DEATH ADJUSTMENT.
201	Billing provider identifier is missing.
202	Billing provider identifier is invalid.
203	Client identification number is missing.
205	PRESCRIBING PROVIDER'S NPI, DEA OR LICENSE IS MISSING.
206	SUBMITTED PRESCRIBER'S ID IS INVALID.
208	PREGNANCY INDICATOR INVALID
210	DISPENSE AS WRITTEN INVALID.
211	REFILL INDICATOR IS MISSING OR INVALID.
212	PRESCRIPTION NUMBER IS MISSING.
213	DATE PRESCRIPTION WRITTEN IS MISSING.
214	DATE PRESCRIPTION WRITTEN IS INVALID.
215	DATE DISPENSED IS MISSING.
216	DATE DISPENSED IS INVALID.
217	GENERIC RETROACTIVE ME ADJUSTMENT.
218	NDC IS INVALID.
219	QUANTITY DISPENSED IS MISSING.
220	QUANTITY DISPENSED IS INVALID.
221	DAYS SUPPLY IS MISSING.
222	DAYS SUPPLY IS INVALID.
223	Required ICD-9-CM diagnosis code is missing or invalid.
224	Detail diagnosis code pointer invalid on paper claim.
225	PATIENT LIABILITY ADJUSTMENT.
226	Referring provider name/number is missing.
227	OTHER PAYER PAYMENT AMOUNT IS INVALID
229	The source of admission is missing or invalid.
231	Performing provider is missing.
232	RATE CHANGE ADJUSTMENT.
233	Number of days, visits or units of service is missing.

CDE_EOB	DSC_EOB
234	PROCEDURE CODE IS MISSING OR INVALID.
235	PROCEDURE CODE NOT IN VALID FORMAT
238	Client's last name is missing.
239	The submitted claim detail through date of service is missing.
240	The submitted claim detail through date of service is invalid.
241	Accident code is invalid.
242	Secondary diagnosis code submitted in an invalid format.
244	Third diagnosis code submitted in an invalid format.
246	Fourth diagnosis code submitted in an invalid format.
247	Exceeds maximum number of claim details allowed.
248	Facility type code is missing.
249	Facility type code is invalid.
250	Claim submitted without any services billed.
251	FIRST MODIFIER IS INVALID.
252	SECOND MODIFIER IS INVALID.
253	THIRD MODIFIER IS INVALID.
258	Primary diagnosis code is missing or invalid
260	UNITS OF SERVICE IS INVALID.
261	Tooth number is missing.
262	Tooth number is invalid.
263	Tooth surface is invalid.
264	DETAIL DATE OF SERVICE IS MISSING.
265	DETAIL DATE OF SERVICE IS INVALID.
268	DETAIL BILLED AMOUNT IS MISSING.
269	DETAIL BILLED AMOUNT IS INVALID.
270	TOTAL CHARGE IS MISSING OR ZERO.
271	TOTAL CHARGE IS INVALID.
273	Type of bill is missing.
274	Type of bill is invalid.
275	Admission date is missing.
276	Admission date is invalid.
277	Admission hour is missing or invalid.
278	Admission type is missing.
279	Admission type is invalid.
280	Patient status is missing.
281	Patient status is invalid.
339	Revenue center code is missing.
340	Revenue center code is invalid.
350	Submitted number of details not equal to header submitted detail count field.
360	ADMITTING DIAGNOSIS MISSING.
361	ADMITTING DIAGNOSIS CODE INVALID.
363	PRINCIPAL PROCEDURE CODE INVALID.
364	Surgical procedure and date required when operating physician is present.
365	PRINCIPAL PROCEDURE DATE IS INVALID OR PRINCIPIAL PROCEDURE CODE IS MISSING
366	FIRST OTHER PROCEDURE CODE INVALID.
367	Second procedure code or date is missing.
368	Second procedure date is invalid.
369	SECOND OTHER PROCEDURE CODE INVALID.
370	Third procedure code or date is missing.
371	Third procedure date is invalid.
372	The fourth surgical procedure code is invalid.
373	The fourth surgical procedure code or date is missing.
375	The fifth surgical procedure code is invalid.
376	The fifth surgical procedure code or date is missing.
381	Attending provider number is missing.
389	Required procedure code is missing.
395	The from date of service is missing.
396	The from date of service is invalid.
397	Through date of service is missing.

CDE_EOB	DSC_EOB
398	Through date of service is invalid.
400	DETAIL UNITS MUST BE GREATER THAN ZERO.
401	The net charge is missing or invalid.
433	MEDICARE DEDUCTIBLE AMOUNT INVALID
436	TOTAL MEDICARE ALLOWED AMOUNT INVALID
450	Invalid area of oral cavity billed.
451	No Medicare coinsurance or deductible billed.
454	Benefits assignment code is invalid. Contact the Provider Assistance Center.
459	Detail diagnosis code pointer invalid on electronic claim.
500	DATE PRESCRIBED IS AFTER THE DATE OF SUBMISSION.
502	DATE DISPENSED IS EARLIER THAN THE DATE PRESCRIBED.
503	DATE DISPENSED IS AFTER SUBMISSION DATE.
505	Total other insurance/spenddown amount is > or = the billed amount.
507	The through date of service is before the from date of service.
508	Total charges do not equal the sum of all detail charges.
509	THE NET CHARGE IS OUT OF BALANCE.
512	CLAIM EXCEEDS TIMELY FILING LIMIT.
513	Client's name and number disagree.
514	The through date of service contains a future date.
518	Total accommodation days billed are not equal to the elapsed days.
519	Admission date is after the from date of service.
521	The through date of service is after the discharge date.
526	The from date of service is illogical.
527	Detail from date of service is after date of submission.
529	Surgical procedure date is prior to admission date.
530	Surgical procedure date is after patient discharge date.
532	DISEASE STATE MANAGEMENT.
533	PDUR DRUG-ALLERGY INTERACTION.
534	PRODUR DRUG-AGE INTERACTION.
535	PDUR INGREDIENT DUPLICATION.
536	PDUR THERAPEUTIC DUPLICATION.
537	PDUR DRUG-TO-DRUG INTERACTION.
539	PDUR EARLY REFILL ON PRESCRIPTION.
540	PDUR MINIMUM DURATION.
541	PDUR DOSING PRECAUTION-HIGH DOSE.
542	PDUR DOSING PRECAUTION-LOW DOSE.
543	PDUR BREAST FEEDING/PREGNANCY PRECAUTION.
544	PDUR MAXIMUM DURATION OF THERAPY.
545	CLAIM EXCEEDS TIMELY FILING LIMIT.
546	DRUG DISEASE MARKER.
547	PDUR LATE REFILL ON PRESCRIPTION.
550	ELECTRONIC ADJUSTMENT IS INVALID.
551	PROVIDER ID ON ADJUSTMENT DOES NOT MATCH MOTHER
555	Claim is past Behavioral Health timely filing guidelines.
559	Medicare coinsurance amount is greater than the Medicare paid amount.
568	The admission date is after the discharge date.
570	HEADER TOTAL DAYS LESS THAN COVERED DAYS.
571	Primary surgical procedure required when surgical RCC is billed.
572	Quantity disagrees with days elapsed.
574	Dates of service cannot span calendar months.
575	Primary or secondary surgical date is outside of the claims dates of service.
589	MASS ADJUSTMENT
592	CLAIM EXCEEDS TIMELY FILING LIMIT.
600	The number of quadrants billed does not equal the number of units billed.
643	Other Insurance indicator is missing or invalid.
700	RESPITE CARE NOT ALLOWED FOR CLIENTS IN A NURSING FACILITY
701	HOSPICE ROOM AND BOARD NOT COVERED FOR ICF/MR PROVIDER TYPE AND SPECIALTY.
702	HOSPICE ROOM AND BOARD NOT COVERED WITHOUT NURSING HOME AUTHORIZATION.
703	HOSPICE REQUIRED HOURS NOT MET

CDE_EOB	DSC_EOB
704	RCC NOT ALLOWED FOR HOSPICE CLIENT
705	OUTPATIENT CLAIM FOR HOSPICE CLIENT REQUIRES CONDITION CODE
706	SERVICE NOT COVERED FOR HOSPICE CLIENT
707	HOSPICE RADIOLOGY SERVICES REQUIRE MODIFIER
708	CROSOVER NOT COVERED FOR HOSPICE
709	PHARMACY SERVICE NOT COVERED FOR HOSPICE CLIENT
780	PRICED AT ENCOUNTER PAID AMOUNT
781	DATE OF SERVICE PRIOR TO EDS ENCOUNTER SUBMISSION.
782	NETWORK BILLING PROVIDER REQUIRED FOR ENCOUNTER.
783	NETWORK PERFORMING PROVIDER REQUIRED FOR ENCOUNTER.
784	INVALID ENCOUNTER ADJUSTMENT
785	OTHER PAYER ID INCONSISTENT WITH SUBMITTER.
786	INVALID SUBMITTER ID FOR ENCOUNTER.
788	ENOCUNTER SUBMITTED FOR INVALID CLAIM TYPE
789	ENCOUNTER OTHER PAYER ICN IS MISSING
790	ENCOUNTER DENIED DETAIL
800	LOCATION CODE INVALID.
801	QUANTITY BILLED DOES NOT EQUAL PACKAGE SIZE.
802	PROVIDER QUALIFIER MISSING OR INVALID.
803	THE PATIENT CONTROL NUMBER IS MISSING.
804	PRESCRIPTION QUALIFIER IS INVALID.
805	PRESCRIBER QUALIFIER IS INVALID.
806	OTHER PAYER ID QUALIFIER IS INVALID OR NOT APPLICABLE.
807	Diagnosis code qualifier is invalid.
808	Other amount claimed submitted qualifier is missing or invalid.
809	Other insurance carrier code is missing, invalid or not applicable.
810	The other insurance amount is missing or not applicable.
811	CONNPACE CLAIM WITH OTHER INSURANCE PAYMENT IS NOT COVERED.
812	Patient status is not billable for the Connecticut Medical Assistance Program.
813	Claim denied after Medical Policy review.
814	CLAIM DENIED FOR MEDICAL POLICY REVIEW.
815	CLIENT'S LAST NAME IS NOT VALID.
816	CLIENT'S FIRST NAME IS NOT VALID.
817	Client's first name is missing.
818	Invalid processor control number.
819	REJECT CODE REQUIRED.
820	REJECT CODE NOT ACCEPTED FOR TPL BILLING.
821	Nursing home dates of service not payable when billed in current month.
822	Crossover with missing/invalid data.
824	OTHER INSURANCE CARRIER CODE IS MISSING
825	CLIENT NAME DISAGREES WITH NAME ON FILE
830	OTHER AMOUNT SUBMITTED INVALID FOR COVERAGE CODE
840	HCPC REQUIRED WHEN DRUG REVENUE CODE IS BILLED
841	UNITS OF MEASURE REQUIRED FOR NDC
842	NDC UNITS MISSING OR INVALID
843	TOO MANY VALUE CODES WITH MEDICARE COINSURANCE
850	Medicare crossover claims containing deductible cannot span calendar years.
852	Accommodation days is zero.
853	Admission date is required for services performed in an inpatient hospital.
854	The from date of service must equal the first of the month.
855	NH LEAVE OF ABSENCE REQUIRES OCCURRENCE CODE/DATE
856	Required operating provider number is missing.
857	Overlapping detail dates of service.
858	Immunization administration procedure not covered without immunization code.
859	RN services not covered without nursing care or nursing assessment service.
860	LPN services not covered without nursing care services on same date of service.
861	NDC IS MISSING OR INVALID.
862	Administratively necessary days for this RCC cannot exceed 7.
863	Detail dates of service not within header from and through dates of service.

CDE_EOB	DSC_EOB
864	Covered and non covered days disagree with total detail units.
865	Ambulance cannot bill mileage separately.
866	Claim cannot exceed 31 days.
867	Long Term Care detail dates of service are inconsistent with units billed.
868	LPN or RN services exceeded.
869	FQHC procedure not covered without other services.
870	CLAIM/DETAIL PAID FULL CO-INSURANCE BILLED.
871	CLAIM/DETAIL PAID FULL CO-INSURANCE AND DEDUCTIBLE BILLED.
872	CLAIM/DETAIL PAID FULL DEDUCTIBLE BILLED.
873	MANUAL PRICE ERROR. CONTACT THE PROVIDER ASSISTANCE CENTER.
874	Service included in hospital per diem rate.
875	HCPC not allowed with revenue center code.
876	HEADER QUANTITY DISAGREES WITH DAYS ELAPSED.
877	DETAIL QUANTITY DISAGREES WITH DAYS ELAPSED.
878	ALLOWED AMOUNT IS ZERO - CONTACT THE PROVIDER ASSISTANCE CENTER.
879	NO CO-INSURANCE OR DEDUCTIBLE DUE FOR OUTPATIENT LAB SERVICES
880	MEDICARE PART B COINS/DEDUCT RECOUPMENT.
885	CLAIM/DETAIL PAID PARTIAL CO-INSURANCE BILLED.
890	CHARTER OAK PAYMENT REDUCED BY CO-INSURANCE AND OR DEDUCTIBLE.
895	MH WAIVER PERFORMING PROVIDER MISSING OR NOT VALID PT/PS
999	RECYCLE CLAIM TABLE OVERFLOW. CONTACT THE PROVIDER ASSISTANCE CENTER.
1000	BILLING PROVIDER IDENTIFIER IS NOT ON FILE.
1001	BILLING PROVIDER INELIGIBLE ON DATE(S) OF SERVICE.
1003	BILLING PROVIDER INELIGIBLE ON DATE(S) OF SERVICE.
1004	PROVIDER NOT ALLOWED TO BILL FROM THIS SERVICE LOCATION
1007	The performing provider is not on file.
1008	PERFORMING PROVIDER MUST HAVE AN INDIVIDUAL NUMBER
1010	Performing provider is not a member of the billing provider group.
1011	PERFORMING PROVIDER NUMBER NOT A VALID FORMAT
1016	MANUFACTURER IS NOT PARTICIPATING IN DRUG REBATE ON DATE OF SERVICE DISPENSED.
1018	No rate on file. Contact the Provider Assistance Center.
1024	PROVIDER IS NOT AUTHORIZED TO BILL FOR THIS CLIENT.
1026	PRESCRIBING PROVIDER'S NPI IS NOT ON FILE.
1051	Performing provider not on file.
1800	CLAIM MUST BE SUBMITTED ELECTRONICALLY.
1801	PROVIDER SANCTIONED BY DEPT OF HEALTH AND HUMAN SERVICES (HHS).
1802	Type of bill is invalid for the provider.
1803	SOCIAL SECURITY NUMBER/EMPLOYER'S IDENTIFICATION NUMBER IS MISSING OR INVALID.
1804	CROSSOVER CLAIMS ARE NOT PAYABLE FOR BEHAVIORAL HEALTH-ONLY PROVIDERS.
1900	INVALID TAXONOMY
1927	THE BILLING PROVIDER'S NPI IS MISSING OR INVALID.
1928	The performing provider's NPI is missing or invalid on the claim.
1931	The rendering provider's NPI is missing or invalid.
1934	The performing provider's NPI is missing or invalid on the claim detail.
1945	CLAIM/DETAIL DENIED. BILLING/PERFORMING PROVIDER COULD NOT BE DETERMINED.
2001	CLIENT ID IS INVALID OR NOT ON FILE. REFERENCE ID CARD FOR CORRECT NUMBER.
2002	CLIENT INELIGIBLE FOR DATES OF SERVICE.
2003	CLIENT INELIGIBLE FOR DATES OF SERVICE.
2010	CLIENT HAS NOT SATISFIED SPEND-DOWN.
2017	SERVICE IS INCLUDED IN MCO COVERAGE.
2057	Client ineligible for portion of claim. Resubmit for covered days only.
2077	Client ineligible for portion of claim detail. Resubmit for covered days only.
2078	CLIENT'S BENEFIT PLAN DOES NOT COVER CROSSOVER CLAIMS.
2079	INCORRECT PROCEDURE CODE USED.
2100	CLIENT NOT FOUND ON ELIGIBILITY MANAGEMENT SYSTEM.
2101	CLIENT IS NOT ELIGIBLE ON ELIGIBILITY MANAGEMENT SYSTEM.
2102	CLIENT ELIGIBILITY SYSTEM IS NOT CURRENTLY AVAILABLE.
2103	UNABLE TO DETERMINE CLIENT ELIGIBILITY DUE TO INVALID CLIENT ID, INVALID DATE O
2104	CONNPACE ID IS IN AN INVALID FORMAT

CDE_EOB	DSC_EOB
2500	Bill Medicare first.
2501	Bill Medicare first.
2502	Bill Medicare first.
2503	Bill Medicare first.
2504	BILL PRIVATE CARRIER FIRST.
2505	Bill private carrier first. Claim attachment is invalid.
2506	HEADER AND DETAIL OTHER PAYER PAID AMOUNTS DO NOT BALANCE.
2507	Client has more than one private insurance carrier.
2508	PHARMACY MUST BILL PRIVATE CARRIER FIRST.
2509	BILL MEDICARE FIRST.
2513	OTHER PAYER ADJUDICATION DATE IS INVALID.
2514	MEDICARE ELIGIBLE CLIENT MUST ENROLL IN PART D.
2515	CLAIM OTHER PAYER CARRIER CODE IS NOT ON FILE.
2516	Claim adjustment reason code is invalid.
2516	Claim adjustment reason code is invalid.
2517	CLAIM OTHER PAYER ADJUDICATION INFORMATION IS INCOMPLETE
2518	Other Insurance Explanation of Benefits is missing
2519	OTHER PAYER ADJUSTMENT AMOUNT IS INVALID
2520	DUPLICATE CARRIER SUBMITTED
2550	Other payer claim adjustment reason code restriction.
2602	DATES OF SERVICE ARE OUTSIDE LOCK-IN EFFECTIVE DATES.
2603	PROVIDER NOT AUTHORIZED TO BILL FOR CLIENT.
2604	THIS CLIENT'S BENEFIT IS RETRICTED TO A SPECIFIC DIAGNOSIS.
2800	DATE OF SERVICE SUBMITTED IS AFTER THE CLIENT'S DATE OF DEATH.
2801	MEDICARE ELIGIBLE CLIENT MUST ENROLL IN PART D.
2802	PROGRAM REQUIRES COPAY ONLY BILLING FOR MDD.
2803	MED D COVERED DRUG - BILL MEDICARE FIRST.
2804	Claim must be billed as crossover.
2805	Date of service submitted is prior to client's date of birth.
2806	COPAY-ONLY CLAIM > $5.00 NOT ALLOWED.
2807	Client's date of birth is not on file. Contact DSS for eligibility corrrection.
2808	REPRICED BY SAGA GRANT LOGIC
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
3000	Prior authorization services are exhausted.
3002	NDC REQUIRES PRIOR AUTHORIZATION
3003	Prior authorization is required for payment of this service.
3004	Inpatient claim requires prior authorization
3006	Prior authorization dollars are exhausted.
3009	VO PA NOT ON FILE
3010	Out of state non-emergency services require prior authorization.
3019	Prior authorization cutback performed.
3021	DRG requires prior authorization.
3100	PA REQUIRED - DISPENSE THE GENERIC EQUIVALENT.
3101	PA REQUIRED, DISPENSE PREFERRED DRUG.
3102	PA REQUIRED FOR PRESCRIPTIONS GREATER THAN $500.00.
3103	DIAGNOSIS REQUIRES PRIOR AUTHORIZATION.
3104	PA REQ ON NDC-CALL DSS 1-800-233-2503
3300	EXCEEDS MAXIMUM REFILLS ALLOWED.
3301	OPTIMAL DOSAGE EXCEEDED.
3302	THE NDC IS NOT CONSISTENT WITH THE BILLED DIAGNOSIS.

CDE_EOB	DSC_EOB
3303	NDC IS NOT COVERED FOR THE CLIENT'S LIVING ARRANGEMENT.
3304	NDC IS LESS THAN EFFECTIVE/DESI DRUG.
3305	NO REIMBURSEMENT RULE FOR ASSOCIATED PATIENT LOCATION.
3306	CLAIM DETAIL EXCEEDS ALLOWABLE LIMIT. CONTACT THE PROVIDER ASSISTANCE CENTER.
3307	CLAIM NOT SUBMITTED WITH OUTER PACKAGE NDC.
3308	DRUGS ARE INCLUDED IN THE NURSING HOME PER DIEM RATE.
3309	NDC IS NOT COVERED FOR THE CLIENT'S PATIENT LOCATION.
3310	BILLED AMOUNT IS GREATER THAN ALLOWED AMOUNT - PRIOR AUTHORIZATION REQUIRED.
3311	Claim dates of service overlap rate change. Rebill on two separate claims.
3312	Other insurance amount is greater than or equal to the allowed amount.
3313	Freestanding alcohol clinic visits limited to 10 consecutive days.
3314	HEADER DIAGNOSIS RESTRICTION FOR NDC UNDER PROVIDER CONTRACT.
3315	ATP TABLE ERROR. CONTACT THE PROVIDER ASSISTANCE CENTER.
3316	EXCEEDS THE MAXIMUM DAYS SUPPLY ALLOWED
3317	INSTITUTIONAL NDC NOT COVERED
3318	THE NDC IS NOT CONSISTENT WITH THE CLIENT'S GENDER
3600	Procedure billed by provider is not covered under the client's benefit plan.
4001	The diagnosis is not covered by this provider under the client's benefit plan.
4002	NDC NOT PAYABLE FOR PROGRAM.
4004	NDC IS NOT ON FILE.
4007	NDC IS NOT COVERED DUE TO CMS TERMINATION.
4009	PRICE VARIANCE SET - VERIFY UNITS/DOLLARS.
4012	Claim denied after Medical Policy review.
4013	Procedure code is not active for this date of service
4014	No pricing segment is on file.
4021	The procedure billed is not a covered service under the client's benefit plan.
4022	Claim denied after Medical Policy review.
4023	THE NDC IS NOT CONSISTENT WITH THE CLIENT'S GENDER.
4025	THE NDC IS NOT CONSISTENT WITH THE CLIENT'S AGE.
4026	QUANTITY DISPENSED EXCEEDS MAXIMUM ALLOWED.
4030	THE DIAGNOSIS IS NOT CONSISTENT WITH THE CLIENT'S AGE.
4031	The diagnosis is not consistent with the client's gender.
4032	Procedure code is not on file.
4034	The service billed does not meet Connecticut Medicaid age criteria guidelines.
4035	The procedure is not consistent with the client's gender.
4036	Place of service is invalid for this procedure.
4039	The primary diagnosis code is not covered.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	Secondary diagnosis code not on file.
4042	Third diagnosis code is not on file.
4043	Fourth diagnosis code is not on file.
4044	No reimbursement rule for associated client age
4045	Benefit plan restriction on reimbursement agreement.
4046	PROCEDURE CODE BILLED PRIOR TO THE EFFECTIVE DATE
4047	Fifth diagnosis code is not on file.
4052	The admit diagnosis code is not on file.
4053	Principal procedure code is not on file.
4054	Second procedure code is not on file.
4055	Third procedure code is not on file.
4056	The fourth surgical procedure code is invalid.
4057	The fifth surgical procedure code is invalid.
4059	Revenue center code is not on file.
4061	NO REIMB RULE FOR ASSOCIATEDCLAIM TYPE
4068	Service is not active on file on date of service.
4070	MODIFIER RESTRICTION FOR PROCEDURE CODE
4077	Revenue center code not active on file on date of service.
4093	Diagnosis is restricted under the client's benefit plan.
4099	Diagnosis related group not on file.
4113	UNIT DOSE PACKAGING NOT ALLOWED FOR A CLIENT WITH THIS PATIENT LOCATION

CDE_EOB	DSC_EOB
4115	NO ANESTHESIA CONVERSION FACTOR ON FILE. CONTACT THE PROVIDER ASSISTANCE CENTER
4127	BENEFIT PLAN HIERARCHY IS NOT FOUND. CONTACT THE PROVIDER ASSISTANCE CENTER.
4130	PAYER HIERARCHY NOT FOUND. CONTACT THE PROVIDER ASSISTANCE CENTER.
4131	NO BENEFIT PLAN ASSOCIATED TO PAYER. CONTACT THE PROVIDER ASSISTANCE CENTER.
4132	DRG grouper is unable to assign DRG for pricing.
4138	BILLING PROVIDER TYPE/SPECIALTY IS RESTRICTED FOR THE NDC UNDER THE CLIENT'S BE
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.
4142	Provider cannot bill this RCC according to the client's benefit plan.
4148	PERFORMING PROVIDER TYPE/SPECIALTY IS RESTRICTED FOR THE NDC UNDER PROVIDER CON
4149	Billing provider not authorized to bill for submitted procedure code.
4151	Billing provider not authorized to bill for submitted service for client.
4153	NDC CODE IS UNDER MEDICAL REVIEW FOR THIS PROVIDER CONTRACT
4155	No reimbursement rule for the associated facility type
4156	NO RELATIVE VALUE ON FILE FOR ANESTHESIA PROCEDURE. CONTACT THE PROVIDER ASSIST
4160	PROVIDER CONTRACT RESTRICTION FOR NDC UNDER PROVIDER CONTRACT.
4161	Procedure code is restricted under provider's contract.
4162	Revenue center code is restricted under provider's contract.
4164	NDC IS INACTIVE.
4165	Exceeds the allowed days supply.
4182	The ICD-9 procedure is not consistent with the client's gender.
4200	Zero allowed amount. Contact the Provider Assistance Center.
4206	Quantity is restricted for procedure under provider contract.
4207	CLIA certification not on file for billed dates of service.
4208	CLIA laboratory procedure requires a modifier.
4209	Procedure/modifier combination is not active on file on date of service.
4211	Tooth number is non-covered for the procedure code billed.
4212	Services not covered by CLIA certificate.
4219	Type of bill restriction under reimbursement agreement.
4222	NDC CODE IS UNDER MEDICAL REVIEW FOR THIS BENEFIT PLAN
4223	This procedure was denied after DSS review.
4224	Quantity limit exceeded.
4227	The RCC billed is not a covered service under the client's benefit plan.
4229	This diagnosis was denied after DSS review.
4240	Only one date of service allowed per detail.
4244	Diagnosis is not covered under the client's benefit plan.
4245	Fourth modifier invalid for the date of service.
4248	Procedure code requires a modifier.
4249	MODIFIER REQUIRED OR NOT ALLOWED FOR PROVIDER TYPE AND SPECIALTY
4250	No reimbursement rule for the associated provider type/provider specialty
4254	PATIENT LOCATION 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.
4271	Modifier conflict for procedure code under provider contract.
4272	Procedure code and modifier combination is not valid for billing provider.
4311	PRIMARY HEADER DIAGNOSIS RESTRICTION FOR PROCEDURE CODE UNDER PROVIDER CONTRACT
4350	Referring provider is not eligible to refer the service billed.
4361	THE NDC BILLED REQUIRES A DIAGNOSIS CODE.
4371	THIS TYPE OF CLAIM IS NOT COVERED UNDER THE CLIENT'S BENEFIT PLAN.
4373	CLAIM TYPE RESTRICTION FOR NDC UNDER BENEFIT PLAN
4374	Revenue center code is not billable.
4713	AGE RESTRICTION FOR THE NDC UNDER THE PROVIDER CONTRACT
4714	Service billed does not meet age criteria according to the provider's contract.
4715	This revenue center code is not consistent with the client's age.
4733	Diagnosis is restricted for revenue center code under client's benefit plan.
4736	The revenue center code is not consistent with the billed diagnosis.
4742	The procedure is not consistent with the header diagnosis.

CDE_EOB	DSC_EOB
4743	The procedure is not consistent with the detail diagnosis.
4766	The ICD-9 procedure is not consistent with the client's gender.
4775	BILLING PROVIDER NOT AUTHORIZED TO BILL FOR SUBMITTED NATIONAL DRUG CODE.
4801	PROCEDURE NOT COVERED. CHECK: PRIOR AUTHORIZATION, FTC, REFERRING PROVIDER, QU
4803	NDC IS NOT BILLABLE UNDER PROVIDER CONTRACT.
4804	Revenue center code is not billable under provider contract.
4821	Facility type is restricted for procedure under provider contract.
4831	Service is not payable on date of service.
4871	Invalid claim type for procedure code submitted.
4873	Invalid claim type for National Drug Code submitted.
4874	Invalid claim type for revenue center code submitted.
4954	SERVICE RESTRICTION FOR PROCEDURE UNDER BENEFIT PLAN
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.
4963	Gender is restricted for procedure code under provider contract.
4965	BENEFIT PLAN RESTRICTION FOR NDC UNDER PROVIDER CONTRACT
4967	The revenue center code is not consistent with the client's gender.
4975	The revenue center code billed is restricted under the provider's contract.
4980	The procedure billed is restricted under the client's benefit plan.
4984	PROCEDURE RESTRICTION FOR RCC UNDER BENEFIT PLAN.
4985	PROCEDURE RESTRICTION FOR RCC UNDER PROVIDER CONTRACT.
4986	PROCEDURE RESTRICTION FOR RCC UNDER REIMBURSEMENT AGREEMENT.
5000	POSSIBLE DUPLICATE OF A PAID CLAIM OR A CLAIM THAT IS CURRENTLY IN PROCESS.
5001	EXACT DUPLICATE OF A PAID CLAIM OR A CLAIM THAT IS CURRENTLY IN PROCESS.
5007	EXACT DUPLICATE - HEADER OF A PAID CLAIM OR A CLAIM THAT IS CURRENTLY IN PROCES
5008	Duplicate of a paid claim or a claim that is currently in process.
5010	EXACT DUPLICATE DENTAL CLAIM OF A PAID OR PENDING CLAIM.
5011	Duplicate tooth surface or billing provider of a paid or pending claim.
5016	HOSPICE DUPLICATE
5020	Duplicate coinsurance billed.
5021	Duplicate coinsurance billed.
5022	Duplicate coinsurance billed.
5052	ENCOUNTER DUPLICATE MCO ICN
5150	This service is limited to once in a client's lifetime.
5200	Psychotherapy w/evaluation and pharmacological mgmt not covered on same DOS.
5202	Behavioral health and substance abuse intensive OP not covered on the same DOS.
5203	Behavioral health and psychiatric intensive outpatient not covered on same DOS.
5204	Behavioral health and day treatment not covered on the same date of service.
5205	Skilled nursing and prenatal services are not covered on the same DOS.
5206	Duplicate of a service paid.
5207	Duplicate of a service paid.
5208	Duplicate of a service paid.
5209	DUPLICATE OF A SERVICE PAID.
5210	Service previously paid under another procedure code.
5211	Duplicate dental service.
5212	Duplicate alveoloplasty service.
5213	Pharmacological management and E&M codes not covered on the same DOS.
5214	Demo and congregate services not covered on the same date of service.
5215	Congregate and demo services not covered on the same date of service.
5216	Medication code and intensive OP/day treatments not covered on the same DOS.
5217	PERSONAL SUPPORT AND SUPPORTED LIVING/RES HABILITATION NOT COVERED ON SAME DOS.
5218	ALS and ground mileage not covered on the same date of service.
5219	TORCH panels and components are not covered on the same date of service.
5221	General health panel and panel components are not covered on the same DOS.

CDE_EOB	DSC_EOB
5224	Comprehensive metabolic panel and other panels are not covered on the same DOS.
5225	Lipid panel and component are not covered on the same date of service.
5226	Electrolyte and components are not covered on the same date of service.
5227	Acute hepatitis and components are not covered on the same date of service.
5230	Renal panel and other panels are not covered on the same date of service.
5237	Hepatic panel and component are not covered on the same date of service.
5242	Health & behavior assessments not covered on same DOS as psychiatry/eval mgmt.
5244	Only one antepartum care code allowed per pregnancy.
5245	Refitting/reconditioning is not covered same date of service as other services.
5246	Independent living skill/group & ind not covered same DOS day habilitation.
5247	Family training/day habilitation not covered on same DOS cognitive service.
5248	Supported employment not covered same date of service pre-vocational services.
5249	Day rehab/sub abuse/per hour not covered same DOS sub abuse/per day.
5250	Transitional living service not covered same date of service as other services.
5251	Refractive exam not covered same date of service as complete eye exam.
5253	Stationary gas system and liquid oxygen system not covered within 28 days.
5254	Stationary liquid system and portable system not covered within 28 days.
5255	Habilitative services limited to one per date of service.
5256	ADP/MR waiver services and CHC/CBS waiver services not covered on same DOS.
5257	Complete screenings and partial screenings are not covered on the same DOS.
5258	Complete screenings and partial screenings not covered on the same DOS.
5259	Complete HH screenings and partial HH screenings are not covered on same DOS.
5260	Clinic visits and EPSDT screenings are not covered on the same date of service.
5261	Surgical procedures and est patient office visit not covered on the same DOS.
5262	Payment for surgical procedure includes follow up hospital care.
5263	PRIMARY SURGERY MUST BE PAID BEFORE MULTIPLE ADDITIONAL SURGERY CAN BE PAID
5264	Only one new exam allowed every 3 years per provider per client.
5267	Global delivery and separate del/antepartum within 180 days are not covered.
5268	Postpartum service not covered within 60 days of global delivery service.
5269	GLOBAL DELIVERY OR C-SECTION NOT ALLOWED IF SEPARATE BILLED.
5270	TCM-DMR or CHC and DMH services are not covered on the same date of service.
5271	HCBS/MR and ADP/MR services are not covered on the same date of service.
5272	CHC/CBS and ADP/MR services are not covered on the same date of service.
5274	Professional service and non emerg visit in ER/clinic not covered on same DOS.
5275	CHC and TCM-DMR services are not covered on the same date of service.
5276	Skilled nursing and prenatal services are not covered on the same DOS.
5277	Surgical visit and abortion or other procedure are not covered on the same DOS.
5278	Lens replacement service and frame/lens services are not covered on same DOS.
5279	Neuropsychological eval and psychodiagnostic tests not covered within 365 days.
5280	Global delivery and separate delivery/Cesarian cannot be billed separately.
5282	Fitting of prosthesis and lens/frame service not covered on the same DOS.
5284	Client frame service and other lens/frame service not covered on the same DOS.
5285	Frame replacement service and frame/lens service not allowed on the same DOS.
5286	Brainstem invoked response and CAT scan not covered within 3 months.
5287	Routine newborn care and critical care are not allowed on the same DOS.
5289	Laboratory test included in office visit.
5291	New PT visit not payable within three years of an established patient visit.
5292	CANNOT HAVE MULTIPLE PRIMARY SURGICAL PROCEDURES ON SAME DATE OFSERVICE.
5296	PRIMARY ANESTHESIA MUST BE PAID FIRST
5298	Periodic exam is not covered within 6 months of initial exam.
5299	Single first periapical and bitewing/panoramic not covered on the same DOS.
5300	Office visit/consultation and radiology exam are not covered on the same DOS.
5301	Only one new exam allowed every 3 years per provider per client.
5303	Partial dentures are not covered after placement of full upper/lower dentures.
5304	Home Health visit and CHC screen are not covered on the same date of service.
5305	Our records indicate that this tooth has already been extracted.
5306	Intraoral and panoramic x-rays are not covered within 24 months of each other.
5307	First periapical and bitewing/panoramic film are not covered on the same DOS.
5308	Alveolar surgery and extractions are not covered on the same date of service.

CDE_EOB	DSC_EOB
5309	Intraoral/panoramic and bitewing service are not covered on the same DOS.
5310	Comprehensive exam and limited exam are not covered on the same DOS.
5313	Ophthalmology procedure and office visit not covered on the same DOS.
5314	Laboratory test included in office visit.
5316	Duplicate dermatology services are not covered.
5317	Xrays are included in the procedure.
5318	Anesthesia services are not covered.
5319	PA required for > 1 physical therapy evaluation or check-up in 90 days.
5320	PA required for > 1 occupational therapy evaluation or check-up in 90 days.
5321	PA required for more than one hearing evaluation or check-up in 90 days.
5324	Orthodontic screening and provider screening not allowed by the same provider.
5325	Neuropsychological eval and psychiatric evaluation not covered within 365 days.
5327	CHC health screen and clinic visit are not covered on the same date of service.
5328	CHC health screen and routine service are not covered on the same DOS.
5331	Basic panel and general health or comp panel not covered on the same DOS.
5332	Electrolyte panel and basic metabolic panel not covered on the same DOS.
5334	Partial dentures are not covered after placement of full upper/lower dentures.
5335	Office visit and surgery are not covered on the same date of service.
5336	Duplicate dental procedure.
5337	Outpatient psychiatric services not covered same day as psych/partial hospital.
5338	OP psychiatric service not covered within 2 days of psych/partial hosp stay.
5340	PA required for > 1 speech and language evaluation or check-up in 90 days.
5342	PA required for > 1 speech and hearing evaluation or check-up in 90 days.
5343	Dental screenings and orthodontic consults not covered for the same provider.
5344	Dental screening and orthodontic screening are not covered on the same DOS.
5345	Home health and CHC services are not covered on the same date of service.
5346	Mileage is not payable for multiple patient ambulance trips.
5400	ASSERTIVE COMMUNITY TREATMENT AND RECOVERY ASSISTANT IS NOT COVERED ON THE SAM
5401	ASSERTIVE COMMUNITY TREATMENT AND PEER SUPPORTS IS NOT COVERED ON THE SAME DATE
5402	RECOVERY ASSISTANT IS NOT COVERED SAME DATE OF SERVICE AS HOMEMAKER, COMPANION,
5403	TRANSITIONAL CASE MANAGEMENT NOT COVERED SAME DATE OF SERVICE AS TARGETED CASE
5404	ASSERTIVE COMMUNITY TREATMENT AND COMMUNITY SUPPORT IS NOT COVERED ON THE SAME
5405	ASSISTIVE LISTENING DEVICE NOT COVERED WITHIN THREE YEARS OF HEARING AID
5406	MEDICAL ABORTION PROCEDURE INCLUDES ALL ASSOCIATED SERVICES (HCG, ULTRASOUND, P
5511	SUSPECT DUPLICATE OF A LAB SERVICE
5550	OP detox not covered on same or overlapping dates as inpatient services.
5551	Services not covered on same/overlapping dates of service as inpatient stays.
5552	Service not covered on same/overlapping date of service as nursing home stay.
5553	Rental not covered after purchase.
5650	REPRICED DUE TO MULTIPLE SURGERY PRICING METHODOLOGY.
5950	HOSPITAL RESERVE CANNOT EXCEED 15 DAYS/ DISCHARGE
6000	CLAIM WAS MANUALLY PRICED OR DENIED FOR MISSING INFORMATION.
6001	End stage renal disease daily codes limited to one per day.
6002	End stage renal disease daily codes limited to one per day.
6003	Personal services are limited to one per day.
6004	PA required for more than 14 dialysis treatments per calendar month.
6005	End stage renal disease monthly codes are limited to one per month.
6006	Only 96 Personal Care Assistance units allowed per date of service.
6007	Prior authorization required for more than 1 evaluation per calendar year.
6008	Personal response system limited to two per month.
6009	Substance abuse program limited to 56 days per year.
6010	ABI procedure exceeded $10,000 per year maximum.
6012	ABI services limited to 40 hours per week.
6013	Purchase of feeding pump is limited to one per three years.
6014	Purchase of feeding tubes are limited to one per day.
6015	Limit of one infusion pump per calendar month.
6016	Purchase of parenteral infusion pumps are limited to one per three years.
6017	PA required for rental after 3 months of continuous rental by same provider.
6018	Only one enteral feeding or parenteral nutrition supply kit per day.

CDE_EOB	DSC_EOB
6020	Transitional living services limited to 183 days per client lifetime.
6021	PA required for more than 86 treatment services per calendar month.
6022	PA required for more than 90 treatments per calendar year with diagnosis.
6023	Purchase of IV poles is limited to 3 per year.
6024	PA required for more than 1 evaluation in 365 days.
6026	1 initial pers service allowed per client per billing and performing provider.
6027	CHC mental health counseling limited to 1 per provider/client/date of service.
6028	Meal service limited to 1 per date of service.
6029	Only 1 pers service allowed per calendar month.
6032	PA required for more than 5 occupational therapy visits per month.
6033	PA required for > 9 occupational therapy visits per cal year with diagnosis.
6034	PA required for more than 10 speech therapy visits per month.
6035	PA required for more than 9 speech therapy visits per cal year with diagnosis.
6036	PA required for more than 10 hearing therapy visits per month.
6037	PA required for more than 9 hearing therapy visits per cal year with diagnosis.
6040	Adult day care services are limited to one per day.
6041	Adult day care services are limited to one per day.
6042	Homemaker services limited to 96 units per date of service.
6043	Homemaker services limited to 96 units per date of service.
6044	Only one primary care code per provider per client per date of service allowed.
6045	Only one primary care code per provider per client per date of service allowed.
6049	Exceeds maximum of 9 screens per client age 5 - 21.
6050	Exceeds maximum of 9 clinic screens per client age 5 - 21.
6051	Exceeds maximum of 9 home health screens per client age 5 - 21.
6052	Only 3 developmental screens per client per provider per 365 days.
6053	Exceeds maximum of 11 screens per client age 0 - 4.
6054	Exceeds maximum of 11 clinic screens per client age 0 - 4.
6055	Exceeds maximum of 11 home health screens per client age 0 - 4.
6056	PA required for more than 13 individual therapy visits in 90 days.
6057	Environmental adaptations limited to $30,000 per calendar year.
6058	Only two units of equipment allowed per calendar year.
6059	ONLY 3 HEARINGS PER CLIENT PER PROVIDER PER YEAR.
6062	ONLY 3 INTERPERIOD VISION PER CLIENT PER PROVIDER PER YEAR.
6065	Only 90 days of facility based respite care per calendar year.
6066	Only one respite service per month.
6067	PA required for more than 13 group therapy visits in 90 days.
6069	More than 1 unit per procedure per provider per client requires manual pricing.
6071	Claim for assistant surgeon services was manually priced.
6072	Only one new exam allowed every 3 years per provider per client.
6073	Only 1 dental visit to a client in a nursing facility allowed per 365 days.
6078	Exceeds limit of 9 screens allowed for ages 6 - 21.
6079	Exceeds limit of 6 screens allowed for ages 2 - 6.
6080	Exceeds limit of 5 screens allowed for ages 1 - 2.
6081	Exceeds limit of 6 screens allowed for ages 0 - 1.
6084	PA REQUIRED FOR MORE THAN 2 PHYSICAL THERAPY VISITS PER 7 DAYS.
6085	PRIOR AUTHORIZATION REQUIRED FOR MORE THAN 1 CASE MANAGEMENT PER MONTH.
6088	PA required for more than 13 family therapy visits in 90 days.
6090	Surgical procedure with this place of service requires PA.
6092	PA required for more than two clinic therapy services per calendar week.
6093	PA required > 9 clinic therapy services per calendar year for diagnosis code.
6094	PA required for more than two podiatry therapy services per calendar week.
6095	PA required for more than 4 podiatry therapy services per calendar week.
6096	PA required > 9 home health therapy services per cal year for diagnosis code.
6097	PA required for > 2 Speech/Audiology therapy services per calendar week.
6098	PA required for more than two therapy services per calendar week.
6099	PA required for more than two visits per 365 days.
6100	PA required > 9 podiatry therapy services per calendar year for diagnosis code.
6101	PA required > 9 speech/audiology services per cal yr for diagnosis code.
6102	Exceeds limit of one unit per date of service.

CDE_EOB	DSC_EOB
6103	PA required for more than 1 clinic therapy service per calendar week.
6104	Only 1 neuropsychological evaluation allowed per year.
6105	PA required for fluoride treatment if 21 years or older.
6106	PA required > 9 physical therapy visits per calendar year with diagnosis code.
6107	PA required for > 90 treatment services per year with specific diagnosis.
6108	Only 5 podiatry visits allowed per client per provider per calendar month.
6109	PA is required for more than two visits per 365 days.
6110	Only one panoramic x-ray is covered per 36 months.
6112	PA required for more than 86 treatment services per calendar month.
6114	Only one CHC health screen can be performed on the same date of service.
6115	Only one tooth sealant in 5 years per client and per tooth allowed.
6116	Only one bitewing procedure allowed within a six month period.
6117	Exceeds limit of one denture per 5 years.
6118	Only one dental prophylaxis allowed per six months.
6119	Only one periodic oral exam allowed per six months.
6120	Only one initial oral exam allowed per 3 years.
6121	Hearing test is only allowed when billed with hearing instrument.
6122	Records show that a fluoride treatment has been billed in the past 6 months.
6123	Exceeds limit of one upper partial per 5 years.
6124	Exceeds limit of one lower partial per 5 years.
6126	Only one electromyography procedure allowed per date of service.
6127	DME purchase limited to one per lifetime.
6129	Space shoes are limited to 1 per 3 years.
6131	Hepatitis B immunization limited to 3 times per lifetime.
6133	PA required for more than 13 therapy services in 90 days.
6134	PA required for more than 26 therapy services in 6 months.
6135	Only one Nursing Home status review per 45 days.
6138	More than one visit with client on the same date of service requires PA.
6141	PA is required for more than 12 skilled nursing visits per month.
6145	Exceeds limit of one per 2 years.
6146	Meal service limited to 1 per date of service.
6147	Only one pers service allowed per calendar month.
6148	Only one restoration per tooth surface allowed per year.
6149	Evaluations are limited to one per year.
6150	Only 2 consultations are allowed per provider per client per year.
6153	Psychological evaluations are limited to one per year.
6155	PA required for more than one evaluation per year.
6156	Exceeds maximum of one visit per week.
6158	PA rquired for more than 12 nurse visits per month.
6159	Home Health aide units exceed policy requirements.
6160	PA required for more than 10 therapy services per month.
6161	PRIOR AUTHORIZATION REQUIRED FOR MORE THAN 2 THERAPY VISITS PER WEEK
6163	Only one skilled nursing evaluation allowed per year.
6164	PA required for more than 13 therapy or child guidance visits in 90 days.
6165	PA required for more than 26 therapy or child guidance visits in 6 months.
6166	Only one clinic visit allowed per day per client per provider.
6168	Psychotherapy performed in SNF/ICF requires PA.
6169	Mental health counseling limited to 1 per provider/client/date of service.
6171	Respite care limited to 720 hours per 365 days.
6172	Only one status review allowed per 30 days.
6173	Only one joint or initial assessment per 60 days.
6174	1 initial pers service allowed per client per billing and performing provider.
6177	Only one orthodontic consult per client's lifetime.
6178	Only one preliminary orthodontic assessment per client's lifetime.
6179	End stage renal disease monthly codes are limited to one per month.
6181	Only one visit per day per revenue center code is allowed.
6182	ICF/MR home reserve days billed exceeds the maximum of 36 days per year.
6183	Home reserve days billed exceeds the maximum of 21 days per year.
6184	Procedure requires prior authorization.

CDE_EOB	DSC_EOB
6185	Procedure requires prior authorization.
6186	Complex visit requires PA.
6187	Only 3 units of non-sterile gloves allowed per day.
6188	Only one DMH-TCM service allowed per calendar month.
6189	Only one psychotherapy w/medical evaluation & management allowed per DOS.
6190	Only one psychotherapy w/medical evaluation & management allowed per DOS.
6191	ONE PHARMACOLOGIC MANAGEMENT VISIT PER DAY.
6193	Only one biopsy per day allowed.
6194	Duplicate of a service paid
6195	Duplicate of a service paid
6196	Duplicate of a service paid
6197	Duplicate of a service paid
6198	Duplicate of a service paid
6199	Duplicate of a service paid
6200	Duplicate of a service paid
6201	Duplicate of a service paid
6202	Duplicate of a service paid
6203	Duplicate of a service paid
6204	Duplicate of a service paid
6205	Duplicate of a service paid
6206	Duplicate of a service paid
6207	Duplicate of a service paid
6208	Duplicate of a service paid
6209	Duplicate of a service paid
6210	Duplicate of a service paid
6211	Duplicate of a service paid
6212	Duplicate of a service paid
6213	Duplicate of a service paid
6214	Duplicate of a service paid
6215	Duplicate of a service paid
6216	Duplicate of a service paid
6217	Duplicate of a service paid
6218	Only one equipment service per calendar month.
6219	Only one targeted case management service per calendar month.
6220	Only one service bundle allowed per calendar month.
6221	Only one evaluation allowed per calendar month.
6222	PA required after 3 months of rental.
6223	DME service with facility type code of 31 or 32 requires PA.
6224	Medical management and psychotherapy not covered on the same date of service.
6225	Complex visit requires PA.
6226	Preventative counseling limited to one per day.
6227	Preventative medicine counseling limited to one per day.
6228	Audiologic function test limited to $115.12 per 365 days.
6229	PA required for more than 2 nursing visits per week.
6230	PA required for more than 2 CHC nursing visits per week.
6231	PA required for > 2 services per year for Behavioral Health Partnership.
6232	PA REQUIRED MORE THAN 12 SERVICES PER YEAR FOR BEHAVIORAL HEALTH PARTNERSHIP.
6233	PA REQUIRED FOR MORE THAN 56 AIDE UNITS PER WEEK
6400	TOTAL NON-MEDICAL TRANSPORTATION SERVICES LIMITED TO $1,000 PER CALENDAR YEAR.
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

CDE_EOB	DSC_EOB
6411	ONLY 5 DAYS OF RESPITE CARE IN A NF OR HOSPITAL IS ALLOWED IN ANY 60 DAY PERIOD
6555	EXCEEDED ENTERAL QUANTITY.
6556	DURATION OF THERAPY EXCEEDED.
6557	CHARTER OAK PHARMACY BENEFIT EXCEEDED.
6850	ONLY ONE INITIAL HOSPITAL VISIT ALLOWED PER ADMISSION.
6851	INPATIENT RESERVE DAYS OVER 15 ARE NOT COVERED.
6900	15 DAY LIMIT FOR ALCOHOL RELATED TREATMENT
6901	20 DAY LIMIT FOR DRUG RELATED TREATMENT.
6902	30 VISIT LIMIT FOR DRUG AND ALCOHOL RELATED SERVICES
6903	30 DAY LIMIT FOR DRUG AND ALCOHOL RELATED SVCS
7000	CLAIM SET AN OVERRIDEABLE PRODUR ALERT.
7001	CLAIM GENERATED AN INFORMATIONAL PRODUR ALERT.
7002	DENIED FOR PRODUR REASONS.
7003	CLAIM GENERATED ALERT THAT REQUIRES PA.
7004	CLAIM DENIED FOR PRODUR ALERT.
7500	CLAIM DENIED AFTER DSS REVIEW.
7503	MISSING/INVALID CONFLICT CODE. USE APPROPRIATE CODE AND RESUBMIT.
7504	MISSING/INVALID PRODUR INTERVENTION CODE.
7505	MISSING/INVALID PRODUR OUTCOME CODE.
7506	RESPONSE CLAIM. ORIGINAL CLAIM FAILED A NON-OVERRIDEABLE ALERT. PA REQUIRED.
7507	VALID OUTCOME CODE OF "NOT FILLED" RECEIVED. RESPONSE ACCEPTED, CLAIM REJECTED
7508	QUANTITY DISPENSED ON RESPONSE CLAIM SAME AS ORIGINAL CLAIM.
7510	RESUBMIT VIA PAPER CLAIM WITH PATHOLOGY REPORT ATTACHED.
7511	RESUBMIT VIA PAPER CLAIM WITH OPERATIVE REPORT ATTACHED.
7512	RESUBMIT VIA PAPER CLAIM WITH PRE-OP X-RAY.
7513	RESUBMIT VIA PAPER CLAIM WITH DESCRIPTION OF SERVICE.
8135	CLAIM ADJUSTED DUE TO PATIENT LIABILITY CHANGE.
8183	CLAIM WAS VOIDED DUE TO CLIENT DATE OF DEATH UPDATE.
8186	CLAIM WAS ADJUSTED DUE TO A PROVIDER RATE CHANGE.
8188	PROVIDER RECOUPED CLAIM
8200	CLAIM WAS ADJUSTED AS A RESULT OF A PAYMENT APPEAL.
8201	CLAIM WAS ADJUSTED AS A RESULT OF SAGA REPRICING.
8202	CLAIM HAS BEEN RECOUPED DUE TO TPL AUDIT FAILURE
8203	HMS ADJUSTMENT.
8204	PARTIAL RECOUPMENT BY A PAID CLAIM ADJUSTMENT REQUESTS.
8205	REQUESTED DATA UPDATED BY PAID CLAIM ADJUSTMENT REQUESTS.
8230	HMS Medicare Part A/B Recovery
8231	CLAIM RECOUPMENT DUE TO VOIDED PAYMENT.
8232	CLAIM WAS ADJUSTED AS A RESULT OF A PROVIDER REFUND.
8233	CLAIM WAS ADJUSTED AS A RESULT OF A PARTIAL PROVIDER REFUND
8240	CLAIM WAS ADJUSTED DUE TO A RETRO ME UPDATE
8241	CLAIM WAS HISTORY ADJUSTED DUE TO A RETRO ME UPDATE.
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
8513	CLIENT LOCATION RESTRICTION.
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.
9001	REIMBURSEMENT REDUCED BY THE CLIENT'S CO-PAYMENT AMOUNT.
9002	REFUND CO-PAY FROM ORIGINAL CLAIM TO CLIENT. CLIENT NO LONGER RESPONSIBLE FO
9003	PAID AMOUNT REDUCED TO ZERO DUE TO TPL/PATIENT LIABILITY/APPLIED INCOME/RENT TO
9004	CLAIM HAS BEEN RECOUPED DUE TO TPL AUDIT FAILURE
9005	CLIENT RETROACTIVELY MEDICAID ELIGIBLE- REVERSE THEN REBILL PDP- BILL CO-PAY T
9006	ANNUAL CH OAK RX BENEFIT MET. CLAIM ZERO PAID.
9007	CLAIM REDUCED DUE TO ANNUAL CH OAK RX BENEFIT MET.
9907	TPL AMOUNT APPLIED.

CDE_EOB	DSC_EOB
9908	PRICING ADJUSTMENT - PHARMACY PRICING APPLIED.
9910	PHARMACY DISPENSING FEE APPLIED.
9916	PRICING ADJUSTMENT - UCC RATE PRICING APPLIED.
9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
9919	PRICING ADJUSTMENT - LONG TERM CARE PRICING APPLIED.
9922	PATIENT LIABILITY, APPLIED INCOME OR SPENDDOWN AMOUNT APPLIED.
9923	PAYMENT AMOUNT REDUCED BY 15% CLIENT CONTRIBUTION
9926	CLAIM HAS CUTBACK AMOUNT.
9928	PRICING ADJUSTMENT - ANESTHESIA PRICING APPLIED.
9929	PRICING ADJUSTMENT - LONG TERM CARE PRICING APPLIED USING MULTIPLE RATES.
9930	PRICING ADJUSTMENT - LONG TERM CARE NON COVERED DAYS.
9931	PRICING ADJUSTMENT - LONG TERM CARE SERVICE NOT PAYABLE.
9934	PRICING ADJUSTEMENT - PAY UP TO MAX FEE PRICING APPLIED.
9935	PRICING ADJUSTMENT - MAX FLAT FEE PRICING APPLIED
9939	PRICING ADJUSTMENT - LESSER OF BILLING OR PERFORMING PROVIDER UCC.
9976	PRICING ADJUSTMENT - METROPOLITAN STATISTICAL AREA PRICING APPLIED
9977	PRICING ADJUSTMENT - PROVIDER RCC CUSTOMARY CHARGE PRICING APPLIED
9978	PRICING ADJUSTMENT - DEFICIT REDUCTION ACT (DEFRA) PRICING APPLIED.
9979	PRICING ADJUSTMENT - OUTPATIENT HOSPITAL LAB FEE PRICING APPLIED.
9980	Ancillary services included in per diem rate.
9981	REDUCED TO MAXIMUM ALLOWABLE
9990	PRICED AFTER MANUAL REVIEW.
9991	BILLED UNITS HAVE BEEN CUTBACK TO CONTRACT MAXIMUM
9996	REFER TO HEADER EOB
9997	REFER TO DETAIL EOB
9998	REDUCED TO MAXIMUM ALLOWABLE.