

Medicaid EOB Crosswalk

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
A1	1	PROVIDER TYPE INCONSISTENT WITH CLAIM TYPE.
26	2	BENEFICIARY INELIGIBLE FOR DATES OF SERVICE
97	3	PAYMENT FOR SERVICE IS INCLUDED IN ENCOUNTER RATE
59	4	PAYMENT REDUCED TO MAX.ALLOWED/MULT.SURGERY RULES; LESSER PROCEDURE ALREADY PAID
169	5	YOUR CLAIM WAS GIVEN INDIVIDUAL CONSIDERATION AND REIMBURSED ACCORDINGLY.
B7	6	PROVIDER NUMBER HAS NOT BEEN RENEWED. CONTACT GAINWELL ENROLLMENT FOR ASSISTANCE.
128	7	NEWBORN CARE BILLABLE UNDER MOTHER'S ID FOR 7 DAYS
31	8	BENEFICIARY NUMBER NOT ON FILE.
140	9	BENEFICIARY NAME/NUMBER DOES NOT MATCH OUR FILES
B13	10	CLAIM DENIED. PAYMENT HAS ALREADY BEEN MADE ON YOUR ELECTRONIC CLAIM SUBMISSION.
B7	11	PROVIDER NAME AND NUMBER MUST MATCH THE NAME THAT IS ON THE ENROLLMENT FORM.
206	12	REFERRING PHYSICIAN NUMBER IS INVALID
16	13	INDIVIDUAL CHARGES DO NOT EQUAL THE SUM OF THE DETAILS
16	14	OTHER INSURANCE INDICATOR MISSING/INVALID. CORRECT TO 1-YES OR 2-NO AND RESUBMIT
143	15	ALLOWED AMOUNT REDUCED BY SPENDDOWN.
B11	16	VERIFICATION OF COVERAGE INDICATES POLICY IN EFFECT FOR ALL/ PORTION OF DAYS.
16	17	NET CHARGE MISSING.
16	18	REFERRING PHYSICIAN NUMBER REQUIRED AND NOT PRESENT.
251	19	RECIPIENT MEDICAID ID NUMBER MISSING ON AMBULANCE ATTACHMENT.
50	20	CLAIM DENIED. DOES NOT WARRANT AMBULANCE USE.
16	21	REFERRING PHYSICIAN CANNOT BE SAME AS ATTENDING PHYSICIAN
146	22	PRIMARY DIAGNOSIS MISSING OR INVALID
16	23	OUTPT LAB (REV.CDE.300 OR 310) REQUIRES A LAB HCPCS CODE FROM 80002-89399 SERIES
16	24	REFERRING PHYSICIAN NUMBER NOT ON FILE.
16	25	ATTENDING PHYSICIAN NUMBER REQUIRED AND IT IS NOT PRESENT, OR IT IS NOT ON FILE

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16	26	SURGICAL DATE IS MISSING OR INVALID
119	27	ZYBAN SMOKING CESSATION PROGRAM LIMIT OF ONE 90/DAY SUPPLY PER 365 DAYS EXCEEDED
23	28	NO PAYMENT IS DUE BECAUSE OTHER INSURANCE HAS PAID MORE THAN DVHA ALLOWED AMOUNT
16	29	SURGICAL PROCEDURE DATE IS MISSING
B7	30	PROVIDER INACTIVE ON OR DURING DATES OF SERVICE.
16	31	PLEASE RESUBMIT ON APPROPRIATE CLAIM FORM
A1	32	TYPE OF BILL IS INVALID FOR THE SERVICES BILLED.
97	33	PAYMENT OF THIS DETAIL CONSIDERED ON FIRST LINE WITH THIS DATE OF SERVICE BILLED
16	34	ADMISSION DATE IS MISSING OR INVALID
16	35	THE ADMISSION DATE IS LATER THAN THE FROM AND/OR THRU DATE OF SERVICE.
16	36	INAPPROPRIATE CODE. REFER TO THE VT MEDICAID DENTAL FEE SCHEDULE
50	37	ADMISSION CODE DOES NOT WARRANT EMERGENCY ROOM/ SERVICES/ SITUATION.
29	38	CLAIM PAST TIMELY FILING LIMIT-SUBMIT A TIMELY FILING APPEAL
119	39	DIABETIC COUNSELING G0108 IS LIMITED TO 12 SESSIONS PER CALENDAR YEAR
16	40	THE INFORMATION ON THE ATTACHMENT IS NOT VALID.
16	41	FROM DATE OF SERVICE IS MISSING OR INVALID.
16	42	PATIENT STATUS CODE IS MISSING OR INVALID
16	43	ADMISSION CODE OR POA INDICATOR IS MISSING OR INVALID
16	44	FROM DATE OF SERVICE IS INVALID.
16	45	THE DISCHARGE DATE OF SERVICE IS MISSING/INVALID
16	46	THE THRU DATE OF SERVICE IS MISSING OR INVALID
16	47	NDC IS MISSING, PLEASE SUBMIT A CORRECTED FORM.
16	48	INAPPROPRIATE PROCEDURE CODE. PLEASE REFER TO YOUR CURRENT CPT MANUAL
119	49	OADAP RESIDENTIAL INTENSIVE TREATMENT LIMITED TO 30 DAYS PER CALENDAR YEAR
16	50	INAPPROPRIATE BILLING OF MULTIPLE PROCEDURE OR HCPCS OR REVENUE CODES.
4	51	CODE/SERVICE OR CODE/MODIFIER COMBINATION NOT VALID FOR DATE OF SERVICE BILLED

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31	52	THIS SERVICE IS NOT COVERED FOR NON-MEDICAID BENEFICIARIES
16	53	DATE OF SERVICE REQUIRED FOR EACH LINE BILLED.
16	54	THIS CODE HAS BEEN DELETED BY HCPCS. REFER TO MEDICARE UPDATES.
16	55	THE THRU DATE OF SERVICE IS BEFORE THE FROM DATE OF SERVICE.
16	56	DOCUMENTATION NEEDED SUBSTANTIATING NUMBER OF UNITS BILLED.
16	57	BILL CODE ONCE ONLY WITH TOTAL NUMBER OF UNITS. INCLUDE OP NOTES AND/OR EXPLAIN.
16	58	QUANTITY OR UNITS MISSING
16	59	NOTICE OF DECISION ATTACHMENT MISSING
16	60	DETAIL CHARGE IS MISSING
151	61	NO PAYMENT DUE. SPENDDOWN GREATER OR EQUAL TO ALLOWED AMOUNT.
16	62	INCORRECT BILLING OF SPENDDOWN ACCORDING TO INSTRUCTIONS
198	63	THIS SERVICE REQUIRES PRIOR AUTHORIZATION
16	64	REVENUE CODE DOES NOT MATCH DESCRIPTION PROVIDED. PLEASE CORRECT AND RESUBMIT.
16	65	THE PLACE OF SERVICE CODE IS MISSING
96	66	SERVICE OVERLAPS GENERAL ASSISTANCE AND MEDICAID PROGRAMS. GAINWELL WILL RESUBMIT
16	67	PROCEDURE CODE MISSING
16	68	NDC NOT ON FILE
16	69	NDC/PROCEDURE DOES NOT MATCH DESCRIPTION PROVIDED. PLEASE CORRECT AND RESUBMIT.
204	70	NON-COVERED SERVICE FOR PROVIDER AS BENEFICIARY NOT IN PCP PROGRAM.
16	71	PRESCRIBING PHYSICIAN NUMBER MISSING
16	72	DISPENSING DATE MISSING/INVALID.
16	73	ESTIMATED DAYS SUPPLY MISSING
97	74	SERVICE INCLUDED IN OFFICE/MEDICAL VISIT.
45	75	ADA MEMBERSHIP FEE (PROCEDURE CODE W8001) LTD.TO ONCE PER RECIPIENT LIFETIME.
119	76	CLAIM/DETAIL DENIED. DME PURCHASE HAS BEEN REACHED.
16	77	REFILL INDICATOR IS MISSING OR INVALID
143	78	ADJUSTMENT RESULTED IN REDUCED PAYMENT. ACCOUNTS RECEIVABLE SET UP FOR RESIDUAL
16	79	VT MEDICAID HAS A UNIQUE PROCEDURE CODE FOR THIS SERVICE.

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16	80	MEDICAL NECESSITY FORM INCOMPLETE. PLEASE COMPLETE AND RESUBMIT.
16	81	SIGNATURE ON MNF NOT WITHIN 6 MONTHS (ONE YR FOR OSTOMY/ UROLOGIC) OF BILLED DOS
150	82	THIS PAYMENT IS THE RESULT OF AN ADJUSTMENT REQUEST
150	83	THIS RECOUPMENT IS THE RESULT OF AN ADJUSTMENT REQUEST.
88	84	THIS AMOUNT WITHHELD AS A RESULT OF AN OUTSTANDING RECEIVABLE
150	85	THIS CREDIT TRANSACTION IS THE RESULT OF YOUR REFUND REQUEST.
97	86	DETAIL DENIED: CONSIDERED INCLUDED IN A PREVIOUSLY BILLED SERVICE
150	87	THIS CREDIT TRANSACTION IS THE RESULT OF AN GAINWELL CHECK ISSUED TO YOU IN ERROR.
97	88	ANOTHER PAID SERVICE/CODE IS INCLUDED IN THIS ONE. RECOUP IT BEFORE REBILLING.
16	89	BRAND CERTIFICATION INDICATOR MISSING
96	90	CLAIM/DETAIL DENIED. NO PAYMENT DUE WHEN RECIPIENT PAYS CHARGE.
109	91	SERVICE DENIED; NOT COVERED BY VERMONT MEDICAID PROGRAM
3	92	PAYMENT REDUCED DUE TO PRENATAL AND CHILDREN'S HEALTH CARE PROGRAM CO-PAY.
45	93	PAYMENT REDUCED TO MAXIMUM ALLOWABLE AMOUNT.
97	94	A PORTION OR ALL OF THESE DAYS WERE PAID AS AN INPATIENT CLAIM.
23	95	CLAIM CUTBACK DUE TO OTHER INSURANCE PAYMENT
18	96	CLAIM DENIED. EXACT DUPLICATE OF SERVICE PREVIOUSLY PAID.
97	97	REIMBURSEMENT FOR ANCILLARY CHARGES INCLUDED IN PER DIEM RATE
88	98	THIS AMOUNT HAS BEEN APPLIED TO AN OUTSTANDING ACCOUNTS RECEIVABLE.
142	99	PAYMENT REDUCED BY APPLIED INCOME/PATIENT SHARE AMOUNT
16	100	YOUR RESUBMITTED CLAIM'S RA DATE IS ILLEGIBLE.
16	101	PROVIDER NAME MISSING.
16	102	CLAIM IS ILLEGIBLE. PLEASE RESUBMIT A LEGIBLE FORM.
16	103	CLAIM (DETAIL) DENIED. ATTACHMENT DOES NOT MATCH THE CLAIM
23	104	CLAIM DENIED. NO COINSURANCE OR DEDUCTIBLE DUE.
16	105	INITIAL EOB IS NEEDED IN ADDITION TO THE ADJUSTMENT EOB TO PROCESS CLAIM.
204	106	SERVICE NOT COVERED FOR VHAP BENEFICIARY
16	107	CLAIM/DETAIL SUBMITTED WITHOUT ANY SERVICES BILLED.
16	108	REVENUE CODE IS MISSING OR INVALID

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128	109	NEWBORN CARE BILLABLE UNDER MOTHER'S ID UNTIL MOTHER IS DISCHARGED
16	110	MEDICARE BENEFITS SHEET ILLEGIBLE. PLEASE RESUBMIT WITH LEGIBLE COPY
16	111	DEDUCTIBLE NON-COVERED. RECIPIENT IS INELIGIBLE ON THE FIRST DATE OF SERVICE.
B7	112	OUR RECORDS SHOW ATTENDING PHYSICIAN INELIGIBLE ON OR DURING DATE(S) OF SERVICE.
16	113	MEDICARE BENEFITS SHEET DOES NOT MATCH CLAIM
16	114	ATTENDING PROVIDER NUMBER IS INVALID.
16	115	MEDICARE PAID DATE MISSING OR ILLEGIBLE.
151	116	NO CROSS-OVER PAYMENT DUE. OTHER PAYMENT GREATER OR EQUAL TO ALLOWED AMOUNT.
16	117	ATTENDING/PRESCRIBING PROVIDER NUMBER NOT ON FILE.
16	118	THIS SURGICAL PROCEDURE CODE IS NOT A VALID ICD-PCS PROCEDURE CODE.
199	119	EXPLAIN USE OF ICD-9 PROCEDURE CODES 87-9999 WITH SURGERY-RELATED REVENUE CODE
16	120	PSRO INDICATOR MUST BE A C1 OR C5
252	121	REQUESTED PRIOR AUTHORIZATION HAS BEEN DENIED. NOTE STATUS ON RETURNED PA FORM.
198	122	THIS PRIOR AUTHORIZATION HAS ALREADY BEEN EXHAUSTED
16	123	ACCIDENT/OCCURRENCE/EMPLOYMENT INDICATOR MISSING.
B12	124	ELECTRONIC ADJUSTMENT CAN NOT BE PROCESSED AT THIS TIME. PLEASE RESUBMIT AFTER 8/23/04.
16	125	ACCIDENT/OCCURENCE DATE MISSING
197	126	PRIOR AUTHORIZATION FROM VDOH IS REQUIRED FOR MORE THAN 20 "AT RISK" VISITS/YEAR
16	127	YOUR RESUBMITTED CLAIM'S RA DATE IS MISSING.
16	128	COMPOUND DRUG ATTACHMENT IS ILLEGIBLE. RESUBMIT CLAIM WITH LEGIBLE ATTACHMENT.
284	129	THIS PROCEDURE CODE/SERVICE DOES NOT MATCH THE PROCEDURE CODE/SERVICE AUTHORIZED
97	130	CAST REMOVAL CODES CAN BE BILLED ONLY FOR CASTS APPLIED BY ANOTHER MD/MD GROUP
97	131	DETAIL DENIED. CAST APPLICATION INCLUDED IN INITIAL CARE.

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16	132	DRUG PREGNANCY INDICATOR INVALID
5	133	PHYSICIAN CANNOT BILL CAST MATERIALS IN A NON-OFFICE SETTING.
24	134	SERVICES PRIOR TO JULY 1 WERE REIMBURSED BY CAPITATION PAYMENT.
151	135	PAYMENT DENIED: LOADING FEE CAP HAS BEEN REACHED.
A1	136	PHYSICIAN'S AUTHORIZATION MUST BE WITHIN 6 MONTHS OF DATE OF SERVICE.
250	137	THE CERTIFICATE NUMBER ON THE ATTACHMENT DOES NOT MATCH THE ONE ON OUR FILE.
16	138	RECIPIENT NAME, DOS, PROVIDER SIGNATURE AND CHARGES REQUIRED ON ATTACHMENT.
16	139	AMOUNT OF SPENDDOWN SHOULD BE ENTERED IN PRIOR PAYMENT FIELD ON UB92 CLAIMS
16	140	ONLY REVENUE CODES 300 OR 310 ARE ALLOWED ON OUTPATIENT CLAIMS WHEN BILLING LAB.
16	141	THESE SERVICES REQUIRE HCPCS/CPT CODES
16	142	INVALID REVENUE CODE FOR SERVICES RENDERED. REFER TO YOUR LIST OF CODES.
97	143	REIMBURSEMENT FOR ANCILLARY CHARGES INCLUDED IN %/PER DIEM RATE FOR BIRTH ROOM
119	144	TIME/UNITS EXCEED(S) THE NORM.PLEASE RESUBMIT WITH EXPLANATION OR DOCUMENTATION
16	145	NON-INJECTED MEDS ADMINISTERED IN THE OFFICE REQUIRE OFFICE NOTES AND INVOICE
3	146	CLAIM PAYMENT AMOUNT REDUCED BY REQUIRED CO-PAY.
197	147	PAYMENT DENIED: REQUIRED AUTHORIZATION WAS NOT OBTAINED IN ADVANCE OF SERVICE.
16	148	PROFESSIONAL REVIEW ORGANIZATION (PRO) CERTIFICATION FORM IS INCOMPLETE.
24	149	THIS IS THE PMPM PAYMENT FOR YOUR PARTICIPATION IN VERMONT PRIMARY CARE PLUS
16	150	EFFECTIVE DATE IS MISSING.
251	151	INFORMATION PROVIDED IN THE REQUIRED FIELD OR FIELDS ON THE CONSENT FORM IS INCORRECT
133	152	THIS ABORTION-RELATED SERVICE HAS BEEN FORWARDED TO ADMIN SERVICES FOR PAYMENT
16	153	REBILL ABORTION RELATED SERVICES SEPARATELY.
16	154	ABORTION CERTIFICATION FORM REQUIRED FOR PAYMENT

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50	155	NON-URGENT SERVICE. RECIPIENT SHOULD BE REFERRED TO IN-STATE FACILITY.
16	156	EFFECTIVE DATE IS INVALID.
97	157	OBSERVATION ROOM SVCS PAID AT PER/DIEM OR PERCENTAGE RATES INCLUDE ANCILLARIES
151	158	APPROVAL IS FOR INPATIENT. PAYMENT REDUCED TO PER DIEM RATE.
16	159	CPT CODE ALLOWED ONLY IN FIELD 81A & ONLY WHEN ICD-9 SURGICAL CODE IN FIELD 80
16	160	THIS MANUFACTURER'S NUMBER IS OBSOLETE. REBILL, USING NEW NUMBER.
96	161	DRUG REFILLS LIMITED TO 5 PER PRESCRIPTION
16	162	LCSW/LCMHC/LMFC PROVIDERS CAN ONLY BILL APPROVED PROCEDURE CODES.
16	163	TOOTH NUMBER IS MISSING
4	164	EPSDT MODIFIERS ARE VALID ONLY IN PAIRS (FOR EXAMPLE: ABAP, NMCI, NMNA, ETC...)
16	165	THE TOOTH SURFACE CODE IS MISSING
B7	166	PROVIDER NOT ELIGIBLE FOR ALL OR A PORTION OF DAYS BILLED.
97	167	REIMBURSEMENT FOR THIS SERVICE IS CONSIDERED AS PART OF YOUR PER DIEM.RATE.
16	168	EPSDT/FAMILY PLANNING INDICATOR MISSING
16	169	PRESCRIPTION NUMBER MISSING/INVALID
16	170	INAPPROPRIATE/INVALID MANUFACTURER NUMBER. REBILL, USING CORRECT NUMBER.
8	171	HOSPITAL BILLS FOR PROCEDURE 863 REQUIRE THE MD'S CPT CODE IN BOX 81A
119	172	HEARING AIDS & DISPENSING FEES LTD TO 1/EAR/3YRS. MORE NEED PA FROM THE DVHA.
50	173	DETERMINED NOT MEDICALLY NECESSARY.
35	174	CLAIM DENIED. YOUR 2 MONTH SUPPLY OF NICORETTE HAS BEEN MET.
198	175	PRIOR AUTHORIZATION DATES ARE NOT ADEQUATE FOR ALL SERVICES BILLED
18	176	THIS SERVICE IS AN EXACT DUPLICATE PER NDC NUMBER AND REFILL NUMBER.
96	177	MAINTENANCE DRUGS FOR A VSCRIPT BENEFICIARY REQUIRE A 90 DAY SUPPLY

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4	178	CODE 11975ZMI IS NORPLANT IMPLANTATION; 11976ZMR IS NORPLANT REMOVAL
35	179	SMOKING CESSATION PROGRAM IS LIMITED TO SIX MONTHS FROM ORIGINAL START DATE
16	180	TOTAL DAYS BILLED ARE NOT EQUAL TO TOTAL ELAPSED DAYS
216	181	SERVICE DENIED. DVHA/PRO REVIEW INDICATES PRECERTIFICATION NOT MET.
16	182	PLEASE RESUBMIT WITH CLARIFICATION THAT SECONDARY CODE IS EITHER ICD-9 OR CPT.
16	183	THESE SERVICES REQUIRE HCPCS/CPT CODES
B7	184	PROVIDER NUMBER NOT CERTIFIED FOR THIS TIME PERIOD
198	185	CLAIM DENIED. SSI RECIPIENT. SERVICE REQUIRES PRIOR AUTHORIZATION FROM KAISER
199	186	ICD-9 SURGICAL PROC.CODE REQUIRED WHEN BILL REV.CODE 360, 361, 362, 367, OR 490.
A1	187	DDMHS/ADAP CASE MGMT & REHAB SERVICE NOT COVERED UNDER THIS PROVIDER NUMBER
16	188	BILLED/SURGICAL DATE OF SERVICE IS INVALID AND/OR DOES NOT MATCH NOTES
35	189	90846 IS LIMITED TO 3 SESSIONS PER RECIPIENT LIFETIME. DVHA AUTH. REQUIRED FOR MORE
183	190	REFERRED/ORDERING PROVIDER MISSING/INVALID/NOT ON FILE/NOT ELIGIBLE ON DOS
97	191	PAYMENT FOR W4888 INCLUDES ALL RELATED SERVICES.
216	192	OTHER INSURANCE ATTACHMENT/MEDICARE EOMB REVIEWED AND DENIED BY DVHA.
23	193	OTHER INSURANCE HAS BEEN CONSIDERED
100	194	PAYMENT HAS BEEN RECEIVED BY BENEFICIARY FOR THIS SERVICE
150	195	CLAIM CUTBACK DUE TO MEDICARE PAYMENT
16	196	NDC IS OBSOLETE
256	197	YEARLY TREATMENT PLAN G9001 NON-COVERED FOR BENEFICIARY - NOT ENROLLED IN PCP
96	198	DESI DRUG NOT COVERED
97	199	PAYMENT DENIED. SECONDARY SURGERY INCIDENTAL TO PRIMARY SURGERY
96	200	DIET PRODUCTS NOT COVERED
A1	201	MANUFACTURER HAS NOT SIGNED REBATE AGREEMENT.

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16	202	MEDICARE PAID AMOUNT ON EOMB IS MISSING OR ILLEGIBLE.
200	203	FUNDING SOURCE/ELIGIBILITY OVERLAP. RESUBMIT AS SEPARATE CLAIMS PER SERVICE
200	204	FUNDING SOURCE/ELIGIBILITY OVERLAP. RESUBMIT AS SEPARATE CLAIMS PER SERVICE
16	205	BILL SAME REVENUE CODE ONLY ONCE, PER DATE OF SERVICE.
A1	206	PRODUCT HAS BEEN REMOVED FROM THE MARKET
A1	207	NATIONAL DRUG CODE NOT COVERED WHEN RECIPIENT IS IN A NURSING HOME
197	208	ADAP "AUTHORIZATION FOR TREATMENT EXTENSION" MISSING FOR THESE DATES OF SERVICE.
119	209	OADAP PRIMARY RESIDENTIAL INTENSIVE TREATMENT IS LIMITED TO 21 DAYS PER EPISODE
16	210	WHEN BILLING FOR NONCONSECUTIVE DAYS, BILL SEPARATE ENCOUNTER CODES
16	211	WHEN BILLING FOR NONCONSECUTIVE DAYS, PLEASE BILL EACH DATE SEPARATELY.
A1	212	SERVICE NON-COVERED WHEN BILLED BY LICENSED OCCUPATIONAL THERAPIST.
96	213	SERVICE NON-COVERED WHEN BILLED BY LICENSED PHYSICAL THERAPIST.
16	214	RECIPIENT DATE OF BIRTH IS MISSING
96	215	THIS SERVICE IS NOT COVERED FOR CRT CLIENT.
16	216	RECIPIENT DATE OF BIRTH DOES NOT MATCH OUR FILES
151	217	CLAIM CORRECTION FORM NOT RECEIVED WITHIN THE 45 DAY LIMIT.
119	218	ADAP INTENSIVE OUTPATIENT TREATMENT (X9007) IS LIMITED TO 30 DAYS PER CAL.YEAR.
119	219	OADAP ADOLESCENT RESIDENTIAL TX (X9005) LIMITED TO 120 DAYS PER YEAR
169	220	ELECTRONIC ADJUSTMENT ACCEPTED SEE NEW ICN
16	221	INVOICE MUST CLARIFY WHICH ITEM IS BEING BILLED AND ITS UNIT COST.
A1	222	THIS CLAIM HAS BEEN DENIED DUE TO A POS REVERSAL TRANSACTION
16	223	URGENT/ELECTIVE ADMISSIONS REQUIRE NOTIFICATION FOR PCPLUS BENEFICIARIES
16	224	MD'S CODE FOR ORTHOTICS & SUPPLIES IS 99070 WITH COMPLETE DESCRIPTION & INVOICE
A1	225	CMHC'S NOT ALLOWED TO BILL VHAP LTD/VHAP MC BENEFICIARIES UNDER THIS NUMBER.

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A1	226	S9480 DAY HOSPITAL SERVICES (PARTIAL HOSP) COVERS ONLY VHAP MC BENEFICIARIES
185	227	ATTENDING PHYS NOT ELIGIBLE MEMBER OF BILLING GROUP FOR ALL/ PART D.O.S. BILLED
16	228	PROOF THAT LIFETIME RESERVE DAYS WERE USED MUST BE INDICATED.
119	229	PCP ATTENDING PREVIOUSLY BILLED FOR Y0069 WITHIN 365 DAYS
16	230	NO DENIAL CODE ON ATTACHED MEDICARE EOMB
5	231	DME NOT COVERED WHEN BILLED PLACE OF SERVICE INPATIENT/ OUTPATIENT
58	232	PHYSICAL THERAPY/CHIROPRACTIC SERVICES NOT COVERED WHEN POS INPATIENT/OUTPATIENT
89	233	TOTAL COMPONENT AND TECHNICAL OR PROFESSIONAL COMPONENTS CANNOT BOTH BE PAID
58	234	SUPPLIES AND MATERIALS NOT COVERED FOR PHYSICIAN WHEN POS INPATIENT/OUTPATIENT
4	235	PHYSICIAN MUST BILL MODIFIER 26 (PROF COMPONENT) WHEN POS INPATIENT/OUTPATIENT
58	236	ONLY SPEC 22 OR 7 PAID FOR CYTOLOGY/PATHOLOGY WHEN POS INPATIENT/OUTPATIENT
4	237	EPSDT MODIFIER REQUIRED FOR THIS SERVICE
133	238	A POST-TREATMENT RADIOGRAPH+THE COMPLETED CLAIM MUST BE SENT TO DDH FOR REVIEW
119	239	SMOKING CESSATION PRODUCTS LIMITED TO TWO SCRIPTS/REGIMENS PER CALENDAR YEAR
A1	240	VERMONT MEDICAID COVERS DME FOR IN-HOME USE ONLY
A1	241	DME SUPPLIER REQUIRED TO HAVE MNF ON FILE
16	242	PLEASE CLARIFY INVOICE TO EXPLAIN BILLED AMOUNT.
16	243	MEDICARE PAID DATE IS ILLEGIBLE.
146	244	ONE OF BILLED DIAGNOSIS IS INVALID, VERIFY IN CURRENT ICD CM MANUAL
16	245	AMBULANCE CERTIFICATION FORM MUST STATE ORIGIN AND DESTINATION OF AMBULANCE.
16	246	AMB.CERT. MUST STATE TYPE OF HOSPITAL ADMISSION (ER OUTPT, INPT ADMIT, OR OTHER)
16	247	CLAIM DOES NOT INDICATE BILLED AMOUNT REDUCED BY SPENDDOWN PER INSTRUCTIONS

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256	248	VHAP MANAGED CARE PROGRAM COVERS ADULT DENTAL SERVICES ONLY UNTIL 11/30/2001
183	249	REFERRING PHYSICIAN NUMBER IS NOT ELIGIBLE.
16	250	ADMISSION CODE IS NOT A VALID VALUE.
16	251	REVENUE CODE IS INVALID
16	252	QUANTITY OR UNITS NOT VALID FOR SERVICE BILLED.
119	253	SMOKING CESSATION PRODUCT LIMITED TO 180 DAYS PER CALENDAR YEAR
16	254	DETAIL DOS NOT WITHIN HEADER FROM DOS TO THRU DOS
A1	255	VSCRIPT/VPHARM COVERS MAINTENANCE DRUGS ONLY
16	256	RESUBMIT FOR BILLING OF NON COVERED SERVICES ONLY.
16	257	DATES ON THE ATTACHMENT-NOTES DO NOT MATCH DOS
B13	258	HOME HEALTH AGENCY HAS BEEN PAID FOR INSTITUTIONAL RESPITE CARE SERVICE.
A1	259	DISREGARD THIS DETAIL. PROCESSING ERROR.
A1	260	RECIPIENT ENROLLED IN SPECIALTY FUNDED PROGRAM WHICH DOES NOT COVER THIS SERVICE
35	261	VDH FAMILY SUPPORT WORKER SERVICES (W0083) ARE LIMITED TO A MAXIMUM OF 20 VISITS
16	262	PLEASE ATTACH OTHER INSURANCE DENIAL PRINT OUT, NOT VT MEDICAID DENIAL.
16	263	FEDERAL STERILIZATION CONSENT FORM REQUIRED.
6	264	BRATTLEBORO RETREAT PROV # RESTRICTED TO PCPLUS INPATIENT- VHAP 18+/MEDICAID 22+
16	265	REHAB THERAPY START DATE IS INVALID
198	266	THE BILLED DATE(S) OF SERVICE IS(ARE) NOT COVERED BY THE GIVEN PA.
31	267	SPECIALLY FUNDED RECIPIENT NOT ELIGIBLE FOR MEDICAID
16	268	APPROPRIATE PROCEDURE CODE FOR HMO CO-PAY IS T1015 AS OF 02/01/04.
16	269	THERAPY PROCEDURE CODE IS 9389
16	270	PCS DATE IS INVALID
16	271	THE THRU DATE OF SERVICE IS INVALID
16	272	THIS CLAIM HAS BEEN PRO-RATED -RECIPIENT WAS NOT ELIGIBLE FOR ALL DAYS BILLED
16	273	ICD-9 SURGICAL PROC.CODE REQUIRED FOR EACH SURGERY DONE. (Y570 IS NOT SURGERY)

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16	274	ESTIMATED DAYS SUPPLY NOT A VALID VALUE
18	275	HISTORY INDICATES POSSIBLE DUPLICATE. IF NOT, RESUBMIT WITH SUPPORTING DOCUMENT.
252	276	RESUBMIT WITH HOSPITAL RECORDS SHOWING DATE & HOUR OF ARRIVAL & OF DISCHARGE
A1	277	THIS CLAIM WAS A PRIOR AUTHORIZATION REQUEST. CLAIM DENIED & SENT TO PA UNIT.
16	278	PROCEDURE/REVENUE CODE NOT ACCEPTED BY VT HEALTH ACCESS AND/OR DOES NOT EXIST.
96	279	NON-COVERED SERVICE.MEDICAID FOLLOWS THE SAME RULES AS YOUR COMMERCIAL INSURANCE
199	280	CPT AND ICD-9 CODES MUST INDICATE/REFLECT SAME SURGICAL PROCEDURE
16	281	CHARGES ON INSURANCE/MEDICARE ATTACHMENT DO NOT MATCH CHARGES ON CLAIM.
197	282	PRIOR AUTHORIZATION HAS NOT BEEN APPROVED FOR DATES OF SERVICE.
198	283	AIR AMBULANCE REQUIRES PA & NEEDS TO BE BILLED ON A HCFA USING PROC CODE A0040
184	284	PRESCRIBING PHYSICIAN NUMBER NOT ELIGIBLE ON DOS
16	285	PHARM.MANAG'MT (90862) CAN'T BE PD SAME DOS AS PSYCHOTX (90804-90844 & 90855).
9	286	SECONDARY DIAGNOSIS CODE IS NOT CONSISTENT WITH THE AGE OF THE RECIPIENT
173	287	PRESCRIBING PHYSICIAN MUST BE AN INDIVIDUAL,NOT A GROUP NUMBER.
16	288	PRESCRIBING PHYSICIAN NUMBER IS NOT ON FILE.
119	289	MR GROUP THERAPY IS LIMITED TO 40 UNITS (10 HOURS) PER WEEK.
8	290	CPT CODE ON UB RESTRICTED TO FIELD 81 & ONLY WHEN PA NEEDED FROM CONTRACTED PRO
119	291	DMH GROUP THERAPY LIMITED TO 2 HOURS (8 UNITS) PER DAY
16	292	BILLED AMT APPEARS INCORRECT COMPARED TO ALLOWED AMT. PLEASE VERIFY AND RESUBMIT
136	293	MEDICAID PAID DED/COINS.AMT. SUBMIT TO OTHER INSURANCE FOR REMAINING PYMT
A1	294	YEARLY TREATMENT PLAN CANNOT BE BILLED BY NON-LOCKIN PCP PROVIDER
251	295	RECIPIENT PLACEMENT LEVEL IS NOT A VALID VALUE.

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119	296	MASTECTOMY BRAS (L8000) ARE LIMITED TO 2 PER PATIENT PER CALENDAR YEAR.
182	297	INVALID MODIFIER ORDER. PLEASE CONTACT PROVIDER SERVICES WITH ANY QUESTIONS.
119	298	DISPENSING FEE LIMITED TO ONCE PER LENS WITHIN TWO YEARS.
119	299	MR GROUP THERAPY IS LIMITED TO 8 UNITS (2 HOURS) PER DAY.
251	300	CLAIM DENIED. RESEARCH INDICATES INCORRECT BILLING.
16	301	REBILL CORRECT CODE WITH TOTAL CHARGE.
A1	302	CLAIM DENIED. REBILL PAPER CLAIM WITH REQUIRED ATTACHMENTS.
16	303	THERAPY PROC CODE 9389 AND START DATE MUST BE IN ONE OF THE SURGICAL PROC FIELDS.
16	304	ORIGINAL EOMB IS NEEDED IN ADDITION TO THE ADJUSTMENT EOMB TO PROCESS THIS CLAIM
A1	305	CLAIM DENIED. MEDICARE'S ADJUSTMENT EOMB REQUIRED.
A1	306	MEDICARE REQUIRES ADDITIONAL INFORMATION. REBILL WITH FINAL DECISION AND EOMB.
A1	307	NON-CONSECUTIVE DAYS MUST BE BILLED SEPARATELY.
4	308	THIS MODIFIER IS NOT VALID FOR THE SERVICE BILLED.
96	309	THESE CONSECUTIVE/SIMILAR CODES CANNOT BE BILLED SIMULTANEOUSLY (SAME DOS)
A1	310	THIS MODIFIER/MODIFIER COMBINATION IS NOT ACCEPTED BY VERMONT MEDICAID/DVHA.
16	311	OVERLAPPING ELIGIBILITY. RESUBMIT WITH EOMB AND AN ITEMIZED STATEMENT OF CHARGES
4	312	DETAIL DENIED. THIS PROCEDURE CODE REQUIRES A MODIFIER.
4	313	THIS PROCEDURE CODE DOES NOT REQUIRE/ALLOW A MODIFIER
16	314	DIFFERENT MEDICATIONS INFUSED ON SAME DAY NEED MODIFIER 02 OR 03 ON CODE Y9873.
16	315	PLEASE INDICATE START DATE FOR COINSURANCE AND AMOUNT OF COINSURANCE FOR ELIGIBLE DAYS
97	316	A PORTION OF THIS CLAIM WAS PREVIOUSLY PAID. RESUBMIT SEPARATELY.
4	317	DIAGNOSIS INDICATES EPSDT MODIFIER REQUIRED ON PROCEDURE CODE
119	318	REHAB THERAPIES ARE LIMITED TO A MAXIMUM OF 1 HOUR PER DAY.
119	319	REPLACEMENT LIFTER SLING (EO621) IS LIMITED TO ONE PER 365 DAYS
16	320	THIS CROSSOVER SERVICE REQUIRES A PAPER CLAIM WITH MEDICARE'S EOMB ATTACHED.
16	321	REBILL A PAPER CLAIM WITH EOMB.

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
96	322	CRNA'S CAN ONLY BE PAID FOR MEDICARE/MEDICAID CROSSOVER CLAIMS.
A1	323	DOCUMENTATION INDICATES HOSPICE RELATED SERVICE. BILL HOSPICE PROGRAM.
198	324	SERVICES/QUANTITIES BEING BILLED DO NOT MATCH THE ALLOWED SVCS./AMTS.ON THE P.A.
A1	325	MEDICARE LIFETIME RESERVE DAYS NOT EXHAUSTED. MEDICAID SERVICE DENIED
16	326	NAME OF INSURANCE COMPANY NOT PRESENT ON ATTACHMENT
A1	327	THIS PROCEDURE CODE VALID FOR CROSS-OVER CLAIMS ONLY. MEDICAID/MEDICARE ELIG.
16	328	MEDICARE EOMB INDICATES LGHP COVERAGE. RESUBMIT WITH DENIAL/ PAYMENT EOB.
97	329	THIS PROCEDURE CONSIDERED INCORPORATED WITHIN ANOTHER CODE PER CPT4 MANUAL.
97	330	THIS SERVICE COVERED WITHIN THE REIMBURSEMENT FOR THE INITIAL/ PRIMARY PROCEDURE
16	331	DOCUMENTATION REQUIRED SUPPORTING TWO SEPARATE OPERATIVE SESSIONS SAME DOS.
4	332	FREE VACCINES/TOXOIDS (EG, STATE SUPPLIED) ARE TO BE BILLED WITH MODIFIER 52.
97	333	CLIENT ENROLLED IN PCPLUS PROGRAM BUT THERE IS NO TPOI SEGMENT FOR M04- INFO ONLY
16	334	HEALTHY BABIES PROCEDURE CODES MUST BE BILLED ON SEPARATE LINES FOR EACH DOS
111	335	BILLING/ATTENDING PHYSICIAN IS NON-PARTICIPATING NON-REIMBURSEABLE
A1	336	PRIOR AUTHORIZATION HAS BEEN CHANGED RESUBMIT NEW CLAIM FOR PROCESSING
11	337	OFFICE VISIT DENIED. ONLY 59425,59426 SHOULD BE BILLED WITH PREGNANCY DIAGNOSIS.
96	338	OFFICE VISIT DENIED. POSTPARTUM CARE SHOULD ONLY BE BILLED WITH CODE 59430
A1	339	PHARMACY CLAIM DENIED. MANUAL REVIEW REQUIRED PLEASE REBILL ON PAPER
16	340	ESRD-RELATED SVCS CANNOT BE BILLED BOTH DAILY AND MONTHLY FOR SAME TIME PERIOD.

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
119	341	MONTHLY ESRD-RELATED SVCS ARE LIMITED TO ONE CODE/CALENDAR MONTH PER RECIPIENT
A1	342	SERVICE DENIED AS BEING SAME OR INCLUDED IN ANOTHER ON SAME DAY
197	343	INP SVCS OVER 24 HOURS FOR CRT CLIENT WITH BEHAV HEALTH DIAG REQUIRE DDMHS PA
4	344	THIS COMBINATION OR ORDER OF MODIFIERS USED IS NOT VALID FOR PROCEDURE CODE BILLED.
16	345	ACCIDENT/OCCURENCE INDICATOR IS NOT A VALID VALUE
16	346	OCCURENCE/ACCIDENT DATE IS NOT A VALID VALUE
4	347	SUBMIT AS ADJUSTM'T TO PAID CLAIM WITH DOCUMENTATION OF MULTIPLE UNITS OR MOD.50
16	348	BILL REPAIR CODES (12001-13300) AS ONE CODE FOR TOTAL LENGTH WITHIN EACH GROUP
16	349	YOUR BILLED AMOUNT INDICATES INCORRECT CODE/BILLING
204	350	PROCEDURE CODE NOT VALID OR NOT ALLOWED FOR USE WITH A GA VOUCHER
16	351	THE INFORMATION ON THE INSURANCE ATTACHMENT IS ILLEGIBLE.
29	352	CLAIM NOT SUBMITTED TO THIRD PARTY LIABILITY IN TIMELY MANNER
96	353	CLAIM DENIED. NO PARTICIPATION IN ELECTRONIC FUNDS TRANSFER PROGRAM
18	354	EOMB STATES DUPLICATE SERVICE. RESUBMIT WITH INITIAL MEDICARE EOMB.
119	355	THE NUMBER OF LEAVE DAYS ALLOWED PER CALENDAR YEAR HAVE BEEN EXHAUSTED
16	356	NDC AGE MISMATCH
242	357	PROVIDER NOT AUTHORIZED FOR THIS SERVICE.
16	358	THE PATIENT STATUS IS NOT A VALID VALUE.
16	359	MEDICARE COVERAGE INDICATOR IS NOT A VALID VALUE
16	360	ENTER THE UNITS DISPENSED, INCLUDING THE NUMBER FOLLOWING THE DECIMAL.
8	361	BILL THE ENCOUNTER PROCEDURE CODE FOR EACH DATE OF SERVICE.
16	362	DATE THAT PHYSICIAN SIGNED THE CONSENT IS ILLEGIBLE. PLEASE CLARIFY.
16	363	HYSTERECTOMY CONSENT FORM REQUIRED.
16	364	PROVIDER SIGNATURE AND DATE ON CONSENT FORM MUST BE ON OR AFTER DATE OF SERVICE

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
16	365	HYSTERECTOMY CONSENT FORM MUST BE SIGNED BY RECIPIENT PRIOR TO SURGERY.
16	366	CONSENT FORM IS ILLEGIBLE. PLEASE CORRECT AND RESUBMIT IT WITH CLAIM.
16	367	EACH PROCEDURE CODE MUST HAVE A CORRESPONDING DATE OF SERVICE (SURGICAL DATE).
16	368	OPERATIVE NOTES/EXPLANATION ILLEGIBLE. PLEASE RESUBMIT WITH LEGIBLE INFORMATION.
4	369	BILL BILATERAL PROCEDURE CODE ONCE ONLY WITH MODIFIER 50 AND ONE UNIT OF SERVICE
16	370	PATIENT STATUS CODE IS NOT A VALID VALUE.
96	371	HOLD BED DAYS NOT ALLOWED FOR LEVEL OF CARE H3 OR H4.
16	372	RECIPIENT PLACEMENT LEVEL IS MISSING.
96	373	LEAVE DAYS NOT ALLOWED WHEN RECIPIENT PLACEMENT LEVEL IS HO1 OR HO2
16	374	MEDICARE COVERAGE INDICATOR IS MISSING
289	375	HOLD BEDS ARE NOT ALLOWED FOR SWING BED CLAIMS.
119	376	BILLED DAYS ARE EQUAL TO MORE THAN ALLOWED FOR BILLED MONTH
96	377	AS OF JULY 01, 1994 HOLD BED DAYS ARE LIMITED TO 6 CONSECUTIVE DAYS.
16	378	NURSING HOME CLAIMS AND WAIVER SERVICES CAN ONLY BE BILLED ONE MONTH PER CLAIM.
16	379	INPATIENT CLAIM DENIED AS IT WAS BILLED WITH NO ROOM CHARGE
16	380	SIGNATURE/DATE REQUIRED FOR CHANGES MADE TO THE ATTACHMENT.
16	381	PLEASE PROVIDE DOCUMENTATION OF LETTER/CLAIM SENT TO OTHER INSURANCE COMPANY
16	382	BLANKET DENIAL ATTACHMENT DATE IS MISSING OR IS VALID TILL END OF CAL YEAR ONLY
16	383	OTHER INSURANCE ATTACHMENT REQUIRES BREAKDOWN OF PAYMENT AND DENIALS.
16	384	ANOTHER PORTION OF YOUR POLICY IS TO BE CONSIDERED FOR COVERAGE.
16	385	DENIAL CODE AND EXPLANATION OF INSURANCE EOB CODE REQUIRED.
16	386	RX NUMBER MISSING OR INVALID
197	387	PRIOR AUTHORIZATION HAS BEEN CANCELLED.
119	388	AMNIOCENTESIS LIMITED TO ONCE PER PREGNANCY.
16	389	PLEASE GIVE REASON MEDICARE A BENEFITS WERE NOT PAID.

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
16	390	INSURANCE COMPANY REQUIRES MORE INFORMATION.
4	391	DATES ON INSURANCE/MEDICARE EOB DO NOT MATCH DATES OF SERVICE ON CLAIM.
22	392	THIS SERVICE IS NOT COVERED BECAUSE OF NONCOMPLIANCE WITH OTHER INSURANCE RULES.
16	393	PLEASE ATTACH A COPY OF YOUR MEDICARE DETERMINATION FORM
18	394	EOB STATES DUPLICATE SERVICE. RESUBMIT WITH INITIAL INSURANCE ATTACHMENT.
16	395	CLARIFY/INDICATE WHICH SERVICE (OR PART OF TOTAL) THIS UNLISTED CODE REPRESENTS.
23	396	NO BENEFITS DUE-MEDICAID POLICY THE SAME AS MEDICARE/INSURANCE FOR THIS SERVICE
16	397	MEDICARE EOB SHEET IS INCOMPLETE OR INVALID. PLEASE CORRECT AND RESUBMIT
102	398	INSURANCE ATTACHMENTS SHOW MAJOR MEDICAL PENDING.
16	399	PLEASE RESUBMIT W/INVOICE SHOWING WHAT YOU PAID FOR SERUM OR OTHER EXPLANATION
16	400	PLEASE BILL MEDICARE FIRST
251	401	MEDICARE (PART A) ATTACHMENT NOT VALID FOR SERVICES BILLED ON THIS CLAIM TYPE.
16	402	SERVICE(S) ON INSURANCE ATTACHMENT ARE MISSING OR DO NOT MATCH CLAIM
111	403	NO CROSS-OVER PAYMENT DUE. PROVIDER DID NOT ACCEPT ASSIGNMENT
16	404	INDICATE AMOUNT PAID BY INSURANCE COMPANY ON THE FRONT OF THE CLAIM FORM.
29	405	CLAIM/DETAIL DENIED, NOT FILED WITHIN THE TIME FRAME ALLOWED
16	406	BENEFICIARY NAME ON INSURANCE\MEDICARE ATTACHMENT DOESNT MATCH CLAIM.
204	407	SERVICE NON-COVERED FOR BENEFICIARY ENROLLED IN PDP (PHARMACY DISCOUNT PROGRAM)
22	408	PLEASE BILL OTHER INSURANCE CARRIER FIRST
16	409	PLEASE PROVIDE DATES OF SERVICE ON INSURANCE ATTACHMENT, SIGN AND RESUBMIT.
119	410	PSYCH ENCOUNTERS PER RECIP/PER BILLING PROVIDER/PER CALENDAR YEAR EXCEED LIMIT
B11	411	RECIPIENT INELIGIBLE FOR A PORTION OF DAYS BILLED

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
B11	412	PATIENT UNAUTHORIZED FOR NURSING HOME FOR A PORTION OF DAYS BILLED.
22	413	RECIPIENT HAS ANOTHER INSURANCE TO BE CONSIDERED.
16	414	PLEASE RESUBMIT INDICATING NUMBER OF TESTS PERFORMED.
16	415	TREATMENT OF ACCIDENTAL INJURY MUST BE PROVIDED WITHIN 72 HOURS OF THE ACCIDENT
96	416	DIAGNOSIS/SITUATION DOES NOT WARRENT EMERGENCY ROOM SERVICE.
A1	417	THIS "LOCK-IN" RECIPIENT CAN ONLY BE TREATED BY SPECIFIC PROVIDER
29	418	CLAIM PAST TIMELY FILING LIMITATION
16	419	PLEASE PROVIDE NAME OF BENEFICIARY ON INSURANCE ATTACHMENT, SIGN AND RESUBMIT
A1	420	WHEN MEDICARE MAKES PAYMENT, BILL ON UB92. OTHERWISE, BILL ON A NURSING HOME TAD
111	421	NO COINSURANCE OR DEDUCT. DUE. PROVIDER DID NOT ACCEPT ASSIGNMENT FROM MEDICARE.
16	422	PLEASE RESUBMIT WITH PURCHASE INVOICE FOR MANUAL PRICING
119	423	PRIOR AUTHORIZATION IS EXHAUSTED WITH THIS PAYMENT.
16	424	PLEASE SEND CLAIM/ATTACHMENTS TO DVHA FOR CONSIDERATION OF LATE BILLING.
197	425	PLEASE SUBMIT CLAIM/ATTACHMENTS TO DVHA FOR REQUIRED PRIOR AUTHORIZATION.
16	426	PAYMENT CANNOT BE MADE WHEN PA IS STATUS I OR S
197	427	MEDICAL NECESSITY AND PRIOR AUTHORIZATION REQUIRED
16	428	REQUIRED ATTACHMENT MUST HAVE AUTHORIZED SIGNATURE.
59	429	VT MEDICAID REIMBURSEMENT FOR MULTIPLE SURGERY APPLIES TO TWO PROCEDURES ONLY.
16	430	"UNLISTED" PROCEDURES REQUIRE DOCUMENTATION. RESUBMIT W/NOTES AND/OR EXPLANATION
16	431	INFORMATION ON MEDICAL NECESSITY FORM DOES NOT MATCH CLAIM
16	432	PLEASE RESUBMIT WITH A MEDICAL NECESSITY FORM.
169	433	PRICING WILL BE OR WAS MANUALLY REVIEWED
16	434	CLAIM DENIED-REQUESTED DOCUMENTATION NOT RECEIVED
16	435	HCPCS HAS A SPECIFIC CODE FOR THIS MEDICATION. SEE THE CURRENT HCPCS LISTING.
16	436	DETAIL DENIED. INADEQUATE OR INSUFFICIENT INFORMATION PROVIDED
16	437	INAPPROPRIATE PROCEDURE/REVENUE CODE. REFER TO YOUR LIST OF ALLOWED CODES.

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
16	438	PA DOES NOT MATCH. VERIFY INFORMATION SENT TO PRO CONTRACTOR/ DVHA/ISSUER OF PA.
59	439	PRIMARY SURGERY IS MANUALLY PRICED AT 100% OF ALLOWED AMOUNT
59	440	SECONDARY SURGERY IS MANUALLY PRICED AT 50% OF ALLOWED AMOUNT
54	441	ASSISTANT AT SURGERY IS PROHIBITED WITH THIS PROCEDURE CODE, PER FEDERAL POLICY
16	442	PLEASE REMOVE OTHER INSURANCE AMOUNT IF IT IS NOT FROM A THIRD PARTY CARRIER.
A1	443	WAIVER CASE MANAGEMENT SERVICES NOT ALLOWED FOR DATES OF SERVICE BILLED.
16	444	THE APPROPRIATE CODE FOR A COMPOUND DRUG IS 99100-1001-00
16	445	NOTES/CONSENT INCOMPLETE AND/OR ILLEGIBLE. PLEASE CORRECT AND RESUBMIT.
252	446	REHAB TX START DATE MISSING OR > 4 MONTHS BEFORE DOS (> 4 MOS OF REHAB NEEDS PA)
16	447	NOTES/CONSENT/INVOICE/ATTACHMENT(S) INVALID.
16	448	ATTENDING PROVIDER NUMBER MUST BE AN INDIVIDUAL PROVIDER NUMBER.
16	449	REHABILITATIVE / HOSPICE SCS SHOULD BE BILLED AS 1 UNIT PER DATE OF SERVICE
8	450	NOT ALLOWED TO BILL THIS CODE AS YOU ARE NOT AUTHORIZED FOR THE LAB SPECIALTY
16	451	COMPOUNDS NEED INGREDIENTS, INGREDIENT NDC'S, QUANTITY AND COMPUTATION OF COST.
16	452	THE QUANTITY OF INGREDIENTS USED IN THE COMPOUND DRUG MUST BE LISTED
16	453	NOT BILLED ACCORDING TO COMPOUND PRICING FORMULA
97	454	ANESTHESIA BY THE OPERATING MD IS INCLUDED WITHIN THE SURGERY CODE PAYMENT
119	455	PROCEDURE MAY BE BILLED IN ONLY ONE UNIT OF SERVICE PER SAME DATE OF SERVICE.
16	456	THIS SERVICE REQUIRED TO BE PROVIDED IN SESSIONS OF AT LEAST ONE-HALF HOUR(U=2)
16	457	NDC INDICATES THE PREGNANCY INDICATOR MUST BE A 1
151	458	CLAIM PRICED AT VERMONT MULTI-SOURCE DRUG PRICE
16	459	TAPE BILLING PROVIDER NOT ELIGIBLE TO BE BILLED FROM THIS SUBMITTER.

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
6	460	NON-COVERED SERVICE-RECIPIENT AGE 21 OR OVER
4	461	LAB INDICATOR INDICATES PROCEDURE WAS PROCESSED OFF-SITE. MODIFIER 26 REQUIRED.
A1	462	PROCESSING ERROR, THIS CLAIM IS BEING RESUBMITTED
16	463	TREATMENT AND PLAN OF CARE MUST BE DOCUMENTED
16	464	DIAGNOSIS RESTRICTED TO "ADULTS". STATEMENT NEEDED TO VERIFY THIS DIAGNOSIS.
7	465	PROCEDURE CODE IS NOT CONSISTENT WITH RECIPIENT'S SEX
6	466	PROCEDURE CODE/SERVICE NOT ALLOWED FOR THIS AGE (OF BILLED BENEFICIARY).
16	467	REVENUE CODE 762 IS THE CORRECT REVENUE CODE FOR OBSERVATION SERVICES.
16	468	CODE 59430 IS FOR THE MOTHER'S SIX-WEEK POSTPARTUM CHECK UP.
16	469	MEDICAL NECESSITY SIGNATURE/DATE IS MISSING/INVALID/ILLEGIBLE.
8	470	99 CODE NOT PERMITTED UNLESS PRIMARY SURGEON USED OR WAS PAID FOR SAME PROC CODE
16	471	FRAMES AND LENSES ARE ONLY BILLABLE BY SOLE-SOURCE SUPPLIER.
B15	472	ASSIST. SURGEON CANNOT BE PAID UNTIL PRIMARY SURGEON HAS BEEN PAID FOR THIS CODE
B15	473	DENTAL PROCEDURE D0275 MAY ONLY BE PAID WHEN BILLED WITH PROCEDURE D0272
16	474	PLEASE RESUBMIT WITH COMPLETE HOSPITAL RECORD
16	475	DATE OF DELIVERY MUST BE ON CLAIM WHEN BILLING D&C FOR POST PARTUM HEMORRHAGE
10	476	DIAGNOSIS CODE IS NOT CONSISTENT WITH THE RECIPIENT'S GENDER
18	477	THIS COMPOUND DRUG IS A DUPLICATE SERVICE PER RX AND REFILL NUMBER.
16	478	ASSISTANT SURGEON MUST USE THE SAME PROCEDURE CODE USED BY THE PRIMARY SURGEON
197	479	PSYCHIATRIC/EMOTIONAL DISORDERS/ SUBSTANCE ABUSE REQUIRE PA FROM PRO CONTRACTOR.
16	480	EXPLANATION REQUIRED RE. MEDICAL NEED FOR GENERAL ANESTHESIA WITH THIS PROCEDURE
97	481	D&C FOR POSTPARTUM HEMORRHAGE NOT COVERED IF PERFORMED WITHIN 7 DAYS OF DELIVERY
16	482	RESUBMIT WITH AUTHORIZED SIGNATURE FROM DDH WHEN YOU ARE BILLING TOOTH (33)

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
16	483	AMOUNT PAID BY OTHER INSURANCE SHOULD BE INDICATED IN THE PRIOR PAYMENT FIELD.
97	484	THESE SERVICES ARE COVERED IN FEE PAID FOR TOTAL OB CARE
16	485	BENEFICIARY NUMBER MISSING ON MEDICAL NECESSITY FORM.
8	486	THE ONLY DVHA-COVERED CHIROPRACTIC SERVICE IS SPINAL MANIPULATION
16	487	MODIFIER 22 NEEDS PROCEDURE NOTES AND AN EXPLANATION TO JUSTIFY INDIVIDUAL CONSIDERATION.
50	488	NITROUS OXIDE NONCOVERED FOR PROVIDER/PATIENT CONVENIENCE.
96	489	CHIROPRACTIC MANIPULATION IS COVERED ONLY FOR SUBLUXATION OF THE SPINE.
16	490	THIS NDC IS NOT VALID FOR DATE OF SERVICE BILLED.
16	491	INDIVIDUAL'S EXPECTED DATE OF DELIVERY (SEE CONSENT FORM) NEEDED FOR PROCESSING.
251	492	EPSDT INDICATOR MUST BE YES IF EPSDT PROCEDURE CODES ARE BILLED.
16	493	MULTIPLE ERRORS ON CONSENT FORM. PLEASE CONTACT COMMUNICATIONS FOR ASSISTANCE
16	494	SEPARATE ER VISITS MUST BE BILLED SEPARATELY. DO NOT COMBINE INTO ONE CLAIM/BILL
16	495	RECIPIENT'S SIGNATURE ON CONSENT FORM MUST BE ON OR BEFORE DATE OF SERVICE
16	496	DATES OF SERVICE ON CLAIM AND CONSENT FORM DISAGREE.
96	497	RECIPIENT MUST BE 21 TO LEGALLY SIGN THE FEDERAL STERILIZATION CONSENT FORM.
16	498	DATE OR DATES ON CONSENT ARE ILLEGIBLE. PLEASE CLARIFY THEM AND RESUBMIT.
16	499	STERILIZATION CAN BE PAID ON 31ST DAY-30 FULL DAYS MUST PASS AFTER PATIENT SIGNS
119	500	STERILIZATION MUST BE 180 DAYS OR LESS FROM DATE CONSENT SIGNED BY RECIPIENT
8	501	PROCEDURE ON CONSENT FORM MUST AGREE WITH CLAIM
16	502	CONSENT FORM INCOMPLETE
16	503	DATE OF HOSPITAL ADMISSION ON OCCUPANCY CERTIFICATION FORM IS INVALID.
16	504	RESUBMIT WITH NOTES AND/OR EXPLANATION OF PROCEDURE/ SITUATION.

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
150	505	DATA SUBMITTED DOES NOT SUBSTANTIATE PROCEDURE (OR REVENUE CODE) BILLED.
197	506	OUR FILES SHOW NO NURSING HOME AUTHORIZATION FOR DOS
A1	507	APPLIED INCOME NOT CURRENT ON ELIG FILE, CONTACT DISTRICT OFFICE FOR CORRECTION
16	508	RESUBMIT WITH NOTES, MED/SURG HISTORY AND DISCHARGE SUMMARY
78	509	CLAIM DENIED. LEAVE DAYS NOT COVERED
119	510	CLAIM DENIED. MAXIMUM LEAVE DAYS EXCEEDED.
16	511	PLEASE RESUBMIT WITH EXPLANATION OF MEDICAL NECESSITY
50	512	BENEFICIARY NOT AUTHORIZED FOR THE RPL FOR ALL/PORION OF DAYS BILLED.
B13	513	CLAIM DENIED. INDEPENDENT LAB HAS ALREADY BEEN PAID FOR THIS SERVICE.
50	514	SUBMITTED DATA DOES NOT JUSTIFY MEDICAL NECESSITY OF ITEM(S) PROVIDED.
96	515	DENIED. STERILIZATION CONSENT MUST BE GIVEN AT LEAST 72 HOURS PRIOR TO PROCEDURE
16	516	PLEASE SUBMIT WITH ADMISSION HISTORY (INCL.SURGICAL) AND DISCHARGE SUMMARY.
16	517	PLEASE SUBMIT WITH DATA AND EXPLANATION SUBSTANTIATING PROCEDURE/TIME/UNITS
119	518	THIS ITEM LIMITED TO TWO UNITS PER 365 DAYS PER RECIPIENT
16	519	PLEASE RESUBMIT EXPLAINING HOW MUCH TIME WAS SPENT FOR THE BILLED PROCEDURE
16	520	PLEASE RESUBMIT EXPLAINING WHY D AND C WAS MEDICALLY NECESSARY.
50	521	DATA SUBMITTED DOES NOT SUBSTANTIATE MEDICAL NECESSITY
50	522	D&C NOT MEDICALLY NECESSARY. REBILL, OMITTING D&C-RELATED SERVICES.
16	523	PROCEDURE 99360 REQUIRES DOCUMENTATION OF MD'S TIME & SERVICES BEYOND THE NORMAL
16	524	PRIOR AUTHORIZATION IS NOT VALID.
96	525	BENEFITS FOR REMOVAL/REPAIR OF ORGANS INJURED DURING SURGERY ARE NOT PROVIDED
16	526	RESUBMIT WITH LAB AND/OR XRAY RESULTS
16	527	ALL ITEMS BILLED MUST BE DOCUMENTED AND JUSTIFIED ON MEDICAL NECESSITY FORM.

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
16	528	JUSTIFICATION REQUIRED FOR MEDICAL NECESSITY FOR THIS LENGTH OF STAY
16	529	RELEVANT HISTORY REQUIRED FOR PROCESSING (HOSPITAL,OFFICE,ETC. REORDS SHOWING HX)
273	530	PAID HOME VISITS ARE LIMITED TO 24 DAYS/YEAR; MORE THAN 2 DAYS/MONTH NEED REVIEW
16	531	DOCUMENTATION FOR GRAFT CODES MUST INCLUDE SIZE OF DEFECT, IN SQUARE CENTIMETERS
16	532	NURSING HOME NAME IN THE REMARKS FIELD DOES NOT MATCH NH AUTHORIZATION ON FILE.
216	533	CLAIM SUSPENSION DUE TO DSW REVIEW OF PER DIEM RATES.
23	534	CLAIM HAS ALREADY BEEN PAID BY INSURANCE CARRIER.
96	535	MEDICARE DENIAL IS "CO" (CONTRACTUAL OBLIGATION). MEDICAID SHOULD NOT BE BILLED.
96	536	STERILIZATION-RELATED SERVICES (INCL.W222)ALLOWED OUTPATIENT ONLY.
16	537	LEAVE DAYS ON NURSING HOME CLAIM DO NOT MATCH FROM/THRU DATES OF SERVICE.
119	538	NORPLANT CONTRACEPTIVE SYSTEM COVERED ONCE IN 5 YEARS, PER RECIPIENT.
119	539	APPLIANCE THERAPY IS LIMITED TO ONCE PER TWO YEARS
16	540	BENEFICIARY NUMBER IS MISSING
16	541	LAB INDICATOR IS MISSING
8	542	NON-INJECTED MEDS FOR HOME USE ARE TO BE BILLED BY PHARMACY PROVIDERS
16	543	ADMISSION CODE "1" IS NOT SUPPORTED BY THE ATTACHED DOCUMENTATION.
197	544	PRIVATE ROOM CHARGES REQUIRE PRIOR AUTHORIZATION OF MEDICAL NECESSITY.
16	545	THE SIGNATURE IS MISSING ON THE OCCUPANCY CERTIFICATION FORM.
16	546	ADJUST TO INCLUDE OUTPATIENT PRE-OP SERVICES ON INPATIENT BILL/ CLAIM.
16	547	BILLED VS. ALLOWED AMOUNTS INDICATE INVALID PROCEDURE OR MODIFIER OR UNITS.
59	548	SEE ANESTHESIA SECTION OF CURRENT CPT FOR GENERAL/REGIONAL ANESTHESIA SERVICES
16	549	SPECIAL PROGRAM/EPSTD/FAMILY PLANNING INDICATOR IS NOT A VALID VALUE

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
5	550	ICD-9-CM PROCEDURE CODES (VOLUME 3) ARE NOT ALLOWED ON HCFA CLAIMS.
8	551	THIS REVENUE CODE IS RESTRICTED TO SPECIFIC PROVIDERS
16	552	INSURANCE ATTACHMENT SHOWS CLAIM PENDING. RESUBMIT WITH FINAL DECISION.
111	553	MANUFACTURER NOT PARTICIPATING IN VERMONT SCRIPT REBATE PROGRAM
16	554	AN OCCUPANCY CERT FORM MUST BE ATTACHED TO HOLD BED SERVICES
16	555	SPLIT & RESUBMIT AS CROSSOVER AND STRAIGHT CLAIM PER MEDICARE EOMB
16	556	BILL SAME CODE ONLY ONCE, WITH MULTIPLE UNITS TO INCLUDE ALL SERVICES.
16	557	THE SIGNATURE DATE ON THE OCCUPANCY CERTIFICATION FORM IS MISSING.
111	558	BEHAVIORAL HEALTH SERVICE DENIED. BENEFICIARY NOT CRT ON DOS.
96	559	THIS BRATTLEBORO RETREAT PROVIDER # RESTRICTED TO INPATIENT AGE 0-21 PA REQ
198	560	PRIOR AUTHORIZATION IS FOR A DIFFERENT PROVIDER/PROVIDER NUMBER.
197	561	AUTHORIZATION BY DDH REQUIRED FOLLOWING COMPLETION OF PROCEDURE.
96	562	ORAL EVALUATIONS (D0120-50) ARE LIMITED TO ONE PER PATIENT PER PROVIDER PER DAY.
198	563	PAYMENT REDUCED TO MATCH AUTHORIZED DAYS
16	564	OCCUPANCY CERT FORM SHOULD INDICATE 100PERC OCCUPANCY FOR EACH HOLD BED DATE ON CLAIM
8	565	THIS SURGERY IS NOT COVERED FOR AMBULATORY SURGICAL CENTERS
96	566	INCORRECT BILLING OF MEDICARE EXHAUSTED BENEFITS.CONTACT PROV. SERV. FOR HELP.
16	567	PLEASE BILL ONE DATE OF SERVICE ON OUTPATIENT DETAILS AND INCLUDE MONTH-DAY-YEAR
96	568	CLAIM DENIED. BILLED AMOUNT EXCESSIVE FOR SERVICES SUBMITTED. REVIEW AND REBILL.
119	569	OADAP RESIDENTIAL DETOXIFICATION LIMITED TO 7 DAYS PER ADMISSION
16	570	OUR HISTORY FILES SHOW NO BILLING FOR MOTHERS DELIVERY ON UB92 CLAIM FORM.
B23	571	CLAIM DETAIL DENIED. NO CURRENT CLIA IDENTIFICATION ON FILE.

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
16	572	ADMISSION DATE SHOULD BE EQUAL TO OR PRIOR TO THE HEADER FROM DATE OF SERVICE.
B11	573	OUR FILE SHOWS RECIPIENT NOT AUTHORIZED FOR ALL DATES BILLED. PATIENT EXPIRED
16	574	MD PRESCRIPTION GIVEN DOES NOT COVER ALL THE DATES OF SERVICE BEING BILLED
16	575	DRUGS FOR HOME/SCHOOL MUST BE BILLED AS ONE LINE FOR TOTAL UNITS.RECOUP & REBILL
9	576	PRIMARY DIAGNOSIS IS NOT CONSISTENT WITH RECIPIENT'S AGE
16	577	THIS CLAIM TYPE REQUIRES A DETAIL DATE OF SERVICE FOR EACH LINE BILLED.
16	578	PRESCRIBING PHYSICIAN ON CLAIM DOES NOT MATCH PA.
16	579	BRAND CERTIFICATION INDICATOR NOT A VALID VALUE
119	580	MAINTENANCE ON OXYGEN CONCENTRATORS LIMITED TO ONCE EVERY TWO MONTHS
16	581	RECIPIENT NAME IS MISSING
197	582	AUTHORIZATION OR MANUAL PRICING IS REQUIRED BY DEPARTMENT VERMONT HEALTH ACCESS
96	583	DATE OF DISCHARGE OR DEATH NOT REIMBURSEABLE (WHEN BILLED DAYS EQUAL ZERO)
16	585	MEDICARE PAID AMOUNT IS ILLEGIBLE
197	586	PARTIAL HOSPITALIZATION FOR CRT CLIENT WITH BEHAVIORAL HEALTH DIAG REQUIRES PA
16	587	NOTICE OF DECISION SPENDDOWN ATTACHMENT INVALID
B20	588	REIMBURSEMENT HAS ALREADY BEEN MADE TO ANOTHER PROVIDER
119	589	OADAP INDIVIDUAL TREATMENT (X9000) LIMITED TO 5 UNITS (1 HOUR,15 MINS) PER DOS
119	590	MAXIMUM DOLLAR AMOUNT FOR PROGRAM HAS BEEN MET
197	591	CARDIAC REHAB REQUIRES DSW PA FOR MORE THAN 36 SESSIONS
111	592	CLAIM DENIED. NO ELECTRONIC FUNDS TRANSFER AGREEMENT ON FILE.
16	593	CLAIM HAS MULTIPLE ERRORS. CONTACT PROVIDER SERVICES IF YOU NEED ASSISTANCE
16	594	CLAIM MUST STATE BILLING FOR BABY UNDER MOTHER'S ID NUMBER
119	595	ADAP GROUP OUTPATIENT (X9001 OR X9011) IS LIMITED TO 8 UNITS (2 HOURS) PER DOS
96	596	ADAP GROUP OUTPATIENT (X9001) MUST BE PROVIDED FOR AT LEAST ONE-HALF HOUR (U=2)

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
16	597	RECIPIENT NAME ON CLAIM DOES NOT MATCH NAME ON NOTES AND/OR CONSENT.
273	598	COCHLEAR (RE)PROGRAMMING LIMITED TO A MAXIMUM OF 18 HOURS PER 365 DAYS/PATIENT
16	599	BENEFICIARY NAME IS MISSPELLED.
16	600	DOCUMENT DRUG'S NAME,STRENGTH,EXACT QUANTITY USED,AND ROUTE OF ADMINISTRATION.
50	601	RADIOLOGY SERVICES DONE FOR THE PURPOSE OF COMPARISON ARE NOT COVERED
24	602	CLAIM PAID AMOUNT GREATER THAN BILLED DUE TO PAYMENT POLICY
16	603	COPY OF PRO'S "RETROSPECTIVE REVIEW CASE SUMMARY" REQUIRED FOR LATE BILLING.
197	604	MORE THAN ONE HOSPITAL VISIT PER DAY,SAME DIAGNOSIS AND PROVIDER REQUIRES P.A.
119	605	NURSING HOME SERVICE PRICED AT 60 DAYS PER CALENDAR YEAR - VHAP RECIPIENT
16	606	PLEASE RESUBMIT YOUR NEW CLAIM WITH YOUR RURAL HEALTH PROVIDER NUMBER
119	607	DME COMPRESSOR NEBULIZERS (E0570) ARE LIMITED TO ONE PER 3 YEARS.
119	608	OBSTETRICAL DELIVERY PAYMENTS ARE LIMITED TO ONCE IN NINE MONTHS.
96	609	THIS OPTOMETRY SERVICE IS NON-COVERED PRIOR TO DOS 7-1-89.
16	610	PSYCHOTHERAPY NOT TO BILL IN UNITS GREATER THAN ONE.
B15	611	PRESCRIPTION AND FIT OF CONTACT LENSES CANNOT BE PAID UNTIL LENS ITSELF IS AUTHORIZED
119	612	DISPENSING FEES FOR FRAMES,CASE AND LENSES MAY ONLY BE BILLED ONE TIME / 2 YEARS
119	613	COST OF LENSES MAY ONLY BE BILLED ONE TIME PER TWO YEARS
96	614	BOTH SURGICAL & MEDICAL BENEFITS NOT ALLOWED FOR SAME VISIT/ SERVICE.
16	615	(Y0069) RECIPIENT NOT ENROLLED WITH ATTENDING PROVIDER AS PCP ON DOS
50	616	DOCUMENTATION SUBMITTED DOES NOT JUSTIFY NEED FOR AIR AMBULANCE -
16	617	SIGNATURE DATE ON OCCUPANCY CERTIFICATION FORM IS PRIOR TO DOS ON CLAIM.

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
16	618	TYPE OF BILL INDICATES CLAIM WHICH SHOULD HAVE ROOM CHARGES BILLED.
31	619	THE MEDICAID ID NUMBER ON OCCUPANCY CERTIFICATION FORM DOES NOT MATCH CLAIM.
16	620	BENEFICIARY NEEDS TO PROVIDE DVHA WITH NAME OF CURRENT INSURANCE COMPANY.
16	621	D3310 LIMITED TO TEETH 6,7,8,9,10,11,22,23,24,25,26,27,56,57,58,59,60,61,62, 63,64,65,66,67
96	622	THIS IS A NON-COVERED SERVICE FOR THIS PROVIDER
16	623	DVHA COVERS D1352 ONLY ON PERMANENT TEETH 1-32
273	624	THE MAX ALLOWED UNITS/\$\$ FOR THIS HEALTHY BABIES ASSESSMENT HAS BEEN REACHED.
16	625	REVENUE CODE IS NOT CONSISTENT WITH THE PROVIDER TYPE - VERIFY PROVIDER # BILLED
16	626	DENTAL PROC CODES D3230, D3240, D7111 ALLOW PRIMARY TEETH A TO T, AS TO TS
16	627	EPSDT/FAMILY PLANNING INDICATOR IS NOT A VALID VALUE
16	628	TOOTH SURFACE CODE IS NOT A VALID VALUE
96	629	SEALANTS COVERED ONLY ON TOOTH #'S 02 03 14 15 18 19 30 31 OR SURFACE IS INVALID
16	630	DDMHS INDICATES NO CRT STATUS FOR DATES OF SERVICE.
16	631	PROVIDER SPECIALTY/REVENUE CODE MISMATCH
16	632	DIAGNOSIS CODE BILLED IS NOT SUBSTANTIATED BY DOCUMENTATION.
16	633	OTHER INSURANCE PYMT NOT APPLICABLE FOR HWU (ACCS) & HDR (DAY HEALTH REHAB)
16	634	THE NUMBER OF UNITS BILLED IS NOT DOCUMENTED BY THE NOTES &/OR CLAIMS' HISTORY.
54	635	CASES INVOLVING CO-SURGERY CANNOT ALSO BILL ASSISTANT SURGEON CHARGES
B12	636	ELECTRONIC VOID ADJUSTMENT ACCEPTED
16	637	THE FACILITY NAME IS MISSING ON THE OCCUPANCY CERTIFICATION FORM.
273	638	THE MAXIMUM ALLOWED (\$176/30DAYS) FOR INFUSION PUMP RENTAL HAS BEEN REACHED.
96	639	MASTECTOMY FORMS (L8020 & L8030) ARE LIMITED TO ONE PER SIDE PER CALENDAR YEAR.
96	640	RESPIRE FOR CAREGIVERS(W0114) IS LIMITED TO 1 PER DAY, 2 PER MONTH.

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
119	641	IEP/ISFP DEVELOPMENT (X0070) IS LIMITED TO A MAXIMUM OF TWO PER 275 DAYS.
B20	642	A PORTION OR ALL OF THESE DAYS WERE PAID AS A NURSING HOME CLAIM
110	643	DATE OF SERVICE IS AFTER THE JULIAN DATE CLAIM WAS RECEIVED OR DOS IS IN FUTURE.
16	644	THE SIGNATURE DATE ON THE OCCUPANCY CERTIFICATION FORM IS ILLEGIBLE.
119	645	D.O.E. PHYSICIAN IEP W0069YE IS LIMITED TO TWICE PER 305 DAYS.
16	646	THE EFFECTIVE AND THRU DATES OF SERVICE MUST BE THE SAME MONTH AND YEAR.
16	647	THE RECIPIENT NAME ON THE OCCUPANCY CERTIFICATION FORM DOES NOT MATCH THE CLAIM.
16	648	CLAIM DENIED. DATE OF SERVICE ON CLAIM IS PRIOR TO PROCEDURE DATE ON P.A.
16	649	USE ZEROES FOR 2ND, 3RD AND 4TH CHARACTERS WHEN BILLING PROCEDURE CODE G0001.
96	650	THIS BENEFICIARY IS NOT ENROLLED IN PCPLUS FOR THIS DATE OF SERVICE
16	651	ATTACHMENT MUST STATE IF PATIENT ABLE TO BE SAFELY TRANSPORTED BY OTHER MEANS
252	652	PATIENT'S SURGICAL HISTORY (NAME OF PROCEDURES, DATES & PROVIDERS) REQUIRED
16	653	TOTAL DAYS BILLED ARE NOT EQUAL TO COVERED DAYS IN BOX 7 ON CLAIM.
119	654	96117 IS LIMITED TO 8 UNITS - HOURS PER YEAR - 365 DAYS
16	655	MODIFIERS RT, LT & RTLT NOT VALID AND/OR NOT ACCEPTED ON THIS PROCEDURE CODE
96	656	AMBULANCE SERVICE PAID FOR BY HOSPITAL WHERE TRIP ORIGINATES. CLAIM DENIED.
16	657	PLEASE SUBMIT PROCEDURE D7880 FOR RECIPIENTS OVER 21 ON A HCFA-1500 CLAIM FORM.
24	658	NO PAYMENT DUE, CAPITATED PAYMENT RECEIVED FROM PRIMARY INSURANCE
119	659	PERIODONTAL SCALING & ROOT PLANING (D4341) IS LIMITED TO 4 UNITS (QUADRANTS)/YR.
150	660	PROVIDER REQUESTED ADJUSTMENT(UNIT DOSE) - ALL UNITS RETURNED - CLAIM RECOUPED

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
119	661	WAIVER RESPITE CARE LIMITATION MET PER CALENDAR YEAR PER BENEFICIARY
96	662	NURSING HOME NOT AT MAX OCCUPANCY FOR ALL/PORION OF HOLD BED DAYS BILLED.
273	663	PAYMENT REDUCED TO MAXIMUM ALLOWABLE AMOUNT FOR PDP (PHARMACY DISCOUNT PROGRAM)
96	664	THIS CLAIM WILL EXCEED THE 24 LEAVE DAYS ALLOWED PER CALENDAR YEAR.
97	665	PAYMENT FOR THIS SERVICE IS INCLUDED IN THE ASC PAYMENT RECEIVED
16	666	THE ONLY DENTAL PROCEDURE CODE ALLOWED ON THE HCFA CLAIM TYPE IS D7880.
251	667	THE RECIPIENT MEDICAID ID NUMBER IS MISSING ON THE OCCUPANCY CERTIFICATION FORM.
16	668	SIGNATURE OTHER THAN PATIENT'S REQUIRES COMPETENCY STATEMENT, PER FEDERAL REG'S
B20	669	CLAIM PAID ZERO DUE TO VA DENTAL CLINIC PROGRAM PROCESSING.
16	670	AMBULANCE ATTACHMENT NOT SIGNED BY PHYSICIAN, RN OR LPN CERTIFYING MED NECESSITY
31	671	CHOICES FOR CARE ELIGIBILITY DOES NOT MATCH SERVICE AND/OR DOS, PLEASE VERIFY AND REBILL
16	672	THIS CLAIM IS ALREADY AWAITING REVIEW. TECHNICAL DENIAL AS DUPLICATE SUBMISSION
272	673	87536 AND ITS COMPONENT CODES CANNOT BE BILLED SIMULTANEOUSLY.
16	674	MODIFIER 51 ALLOWED ONLY ON SECONDARY SURGICAL CODE THAT REQUIRES PRIOR AUTH.
16	675	ROUTINE MAMMOGRAPHY SCREENING (76092) IS NOT REIMBURSEABLE UNDER BCCT PROGRAM
16	676	BILLING PROVIDER NUMBER IS ONLY AUTHORIZED TO BE THE ATTENDING PROVIDER
16	677	D3320 ALLOWS TOOTH # 4, 5, 12, 13, 20, 21, 29, 29, 54, 55, 62, 63, 70, 71, 78, 79
60	678	THE HOSPITAL BILLED THIS STAY AS OUTPATIENT. INPATIENT SERVICES CANNOT BE PAID.
119	679	THE MAXIMUM OF 1600.00 PER DAY PER CLIENT FOR MR SERVICES HAS BEEN MET
B13	680	CLAIM DENIED. EQUIPMENT PURCHASES INCLUDE REIMBURSEMENT FOR ASSEMBLYING.

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
119	681	REPAIRS LTD TO ONCE/YR PER AID. SPECIFY BOTH SERIAL #S & DATES IF DIFFERENT AIDS
16	682	CONTACT LOCAL SOCIAL WELFARE OFFICE FOR SPEND DOWN LETTER AND RESUBMIT CLAIM.
16	683	THE NUMBER OF UNITS ON PHARMACY CLAIMS IS LIMITED TO FOUR DIGITS.
242	684	THIS CLAIM IS DENIED-NO AUTHORIZATION TO SUBMIT ELECTRONICALLY - CONTACT GAINWELL
96	685	DAY HOSPITAL (X2876) CANNOT BE BILLED WITH CHEMO,GROUP, PSYCHOTHERAPY OR DAY RX.
2	686	CLAIM PROCESSED AS MEDICARE PART A. CLAIM RECOUPED. RESUBMIT AS MEDICARE PART B.
18	687	DENIED FOR THERAPEUTIC DUPE
B11	688	OUR FILES INDICATE RECIPIENT NOT ENROLLED IN HOSPICE FOR ALL/ PORTION OF DAYS.
197	689	PRIOR AUTHORIZATION / DIVISION FOR CHILDREN WITH SPECIAL HEALTH NEEDS REQUIRED
96	690	FEDERALLY QUALIFIED HEALTH CENTER CODE T1015 IS LIMITED TO ONE PER DAY
273	691	BILLED AMOUNT EXCEEDS NORM. VERIFY SERVICE CODE, UNITS AND USUAL/CUSTOMARY CHARGE.
16	692	CLARIFICATION OF MEDICARE/INSURANCE DENIAL NEEDED TO PROCESS THIS CLAIM.
16	693	NON-MANAGED CARE RECIPIENT. MUST USE Y570 THERAPY CODE
96	694	ANESTHETIC MANAGEMENT LIMITED TO ONE METHOD PER PATIENT FOR SAME DATE OF SERVICE
B7	695	THIS BRATTLEBORO RETREAT # RESTRICTED TO VHAP PCPLUS INPATIENT AGE 18 +
16	696	THIS DENTAL PROCEDURE CODE DOES NOT ALLOW THE TOOTH NUMBER BILLED
16	697	DETAIL DIAGNOSIS POINTER MISSING/INVALID OR NO DIAGNOSIS FOR POINTED FIELD
22	698	THRU DATE OF SERVICE REFLECTS MEDICARE'S COVERED DAYS
16	699	HOSPITALIZATION STAMP FROM THE DDH IS REQUIRED WITH INPATIENT DENTAL SERVICES
49	700	VT MEDICAID DOES NOT REIMBURSE FOR CARE OF CORNS AND CALLUSES
16	701	CLAIM/DETAIL DENIED. PLEASE RESUBMIT WITH ANESTHESIA RECORD(S).

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
96	702	THIS SERVICE NOT COVERED FOR PERSONS OVER 21 UNLESS FOR PRESURGICAL DIAGNOSIS
58	703	THE PLACE OF SERVICE CODE IS INVALID FOR THIS SERVICE.
8	704	PROCEDURE/REVENUE CODE NOT CONSISTENT WITH PROVIDER TYPE.
8	705	PROCEDURE/REVENUE CODE NOT CONSISTENT WITH PROVIDER SPECIALTY.
11	706	PROCEDURE CODE/REVENUE CODE/HCPCS CODE NOT CONSISTENT WITH DIAGNOSIS.
B22	707	PLEASE RESUBMIT WITH A MORE SPECIFIC DIAGNOSIS
16	708	PRIMARY DIAG CAN'T BE EXTERNAL CAUSE OF INJURY CODE
97	709	POSTPARTUM CARE (59430) INCLUDED IN OTHER PAID/BILLED OB CODE/ SERVICE.
16	710	PLEASE USE APPROPRIATE PROVIDER NUMBER ASSIGNED FOR THIS SERVICE
197	711	CHIROPRACTIC VISITS FOR BENEFICIARIES LESS THAN 12 YRS.OLD REQUIRES PA
58	712	DOCUMENTATION &/OR RECORDS &/OR RESEARCH INDICATES THE BILLED POS IS INCORRECT.
4	713	HISTORY AND/OR CLAIM'S DESCRIPTION/NOTES INDICATES MODIFIER IS NEEDED.
96	714	SAME MD (ATTEND.PROV.#) CANNOT BE BOTH THE SURGEON & THE ASSISTANT SURGEON (80)
16	715	ANESTHESIOLOGIST, CRNA , ANESTH. ASSIT. MUST USE SAME PROCEDURE CODE WITH APPROP. MODIFIER
96	716	SERVICE NON-COVERED FOR ADULTS EFFECTIVE 07/29/2002 PER LEGISLATIVE CHANGES
96	717	VHAP MANAGED CARE NON-COVERED DENTAL BENEFIT. RECIPIENT 18 YEARS OR OVER
119	718	OSTOMY BELTS ARE LIMITED TO 12 PER YEAR
16	719	SERVICE COVERED AS FEE FOR SERVICE - MUST BILL PAPER/TAPE NOT ENCOUNTER CLAIM
16	720	PHARMACY CLAIM HAS A NEGATIVE UNIT OF SERVICE. RESUBMIT NEW CLAIM.
11	721	REVENUE CODE NOT CONSISTENT/ALLOWED WITH DIAGNOSIS.
16	722	PRIMARY DIAGNOSIS FOR A SURGERY CANNOT BE A V-- ("WELL-CARE") DIAGNOSIS CODE.
119	723	HEALTHY BABIES ASSESSMENT (W0073) IS LIMITED TO TWICE PER PREGNANCY.

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
119	724	HEALTHY BABIES ASSESSMENT (W0074) IS LIMITED TO TWICE PER 12 MONTHS (365 DAYS).
2	725	REBILL MEDICARE USING THE CORRECT HIC NUMBER.
119	726	HEALTHY BABIES SERVICES W0075 & W0084 ALLOW A MAXIMUM OF 9 VISITS PER PREGNANCY.
119	727	HEALTHY BABIES SERVICES W0076 & W0084 LIMITED TO A MAX OF 15 VISITS/PREGNANCY.
119	728	THIS HEALTHY BABIES SERVICE IS LIMITED TO A MAXIMUM OF 10 VISITS PER 12 MONTHS.
119	729	THIS HEALTHY BABIES SERVICE IS LIMITED TO A MAXIMUM OF 40 VISITS PER YEAR.
119	730	PSYCHIATRIC DIAGNOSTIC AND EVALUATION INTERVIEWS LIMITED TO 5 UNITS/CALENDAR YR.
119	731	GROUP PSYCHOTHERAPY WEEKLY LIMIT REACHED
119	732	DOH HEALTHY BABIES GROUP EDUCATION (W0082) IS LIMITED TO 6 CLASSES PER 365 DAYS.
16	733	PLEASE INCLUDE CHARGES FOR OBSERVATION ROOM ON ROOM CHARGE LINE.
16	734	NEED COMPLETED COPY OF FEDERAL STERILIZATION CONSENT FORM OR HISTORY & OP NOTES.
16	735	REV. CODE 636 NEEDS HCPCS CODE OR NDC. COVERAGE LTD TO SPECIFIED CONDITIONS/DIAG
252	736	ELECTRONIC ADJUSTMENT REJECTED - ORIGINAL CLAIM NOT FOUND
16	737	ELECTRONIC ADJUSTMENT REJECTED - ORIGINAL CLAIM NOT IN A PAID STATUS
97	738	COST OF ADMINISTERING MEDICINE ALREADY INCLUDED IN PRIMARY CODE.
251	739	RHC/FQHC SUPPLEMENTAL SERVICE BILLED WITHOUT MC PAYMENT AS OTHER INSURANCE
119	740	IEP COMPREHENSIVE EVALUATION (X0069) IS LIMITED TO ONCE PER 3 YEARS PER CHILD.
16	741	TOOTH NUMBER IS INVALID.
119	742	WEEKLY CASE MANAGEMENT T1016 TL IS LIMITED TO SIX UNIT PER CALENDAR WEEK.
96	743	WEEKLY MANAGEMENT (X0071) AND 3-YEAR-EVAL (X0069) CANNOT BE PAID IN SAME MONTH.
256	744	SERVICE NOT COVERED WITHIN SCOPE OF DEPT OF CORRECTIONS PROGRAM

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
119	745	CHIROPRACTIC VISITS LIMITED TO 12 DOS PER CALENDAR YEAR
199	746	WHEN BILLING Y570 WITH SURGERY, ICD SURGICAL PROCEDURE CODE MUST BE IN FIELD 80.
119	747	FOR CODES 77420, 77425 & 77430, AS OF DOS 08/01/95, ONE UNIT EQUALS 5 TREATMENTS
16	748	INCORRECT RECIPIENT NAME ORDER.
A1	749	SERVICE DENIED BY THE OFFICE OF ORAL HEALTH
96	750	MAINTENANCE DRUGS REQUIRE A MINIMUM 60 DAY SUPPLY.
96	751	SEALANTS (D1351 AND D1352) LIMITED TO SURFACES (O,B,L,OB,AND OL) ONLY
119	752	PERMANENT CROWNS LIMITED TO 1 PER TOOTH EVERY 5 YEARS
35	753	PULPOTOMY (D3220) LIMITED TO ONCE PER TOOTH PER LIFETIME
35	754	ROOT CANAL THERAPY LIMITED TO ONE PROCEDURE PER TOOTH PER BENEFICIARY LIFETIME.
2	755	PLEASE BILL RAILROAD MEDICARE CARRIER.
119	756	ENDODONTIC IMPLANTS LIMITED TO 1 PER TOOTH PER 2 YEARS
35	757	D4260,D4270,D4271,&D4280 TOGETHER CANNOT BE BILLED MORE THAN 4 TIMES/LIFETIME
119	758	SRS TARGETED CASE MANAGEMENTG9012/T2023 IS LIMITED TO ONCE PER CALENDAR MONTH.
B7	759	AS OF DOS 01/01/03, W1132 & W1133 ARE FOR PARTS ONLY. SEE E1340 FOR LABOR CHARGE
119	760	PROCEDURE D4340 IS LIMITED TO ONCE PER YEAR, ANY PROVIDER
119	761	PAYMENT FOR DENTURES (ONE UPPER & ONE LOWER) IS LIMITED TO ONCE PER 5 YEARS.
119	762	PROCEDURES D5730-D5760 LIMITED TO 1 PER 180 DAYS
119	763	PROCEDURES D5820-D5840 LIMITED TO 1 PER 365 DAYS
35	764	EXTRACTIONS LIMITED TO ONCE PER TOOTH PER LIFETIME
119	765	BITEWINGS ARE LIMITED TO 4 UNITS PER DATE OF SERVICE PER DDH
96	766	PARTIAL RADIOGRAPHS CANNOT BE BILLED ON SAME DOS AS A COMPLETE SERIES D0210
35	767	PROCEDURES D8460-D8580 LIMITED TO 4 UNITS PER LIFETIME
119	768	D0272 AND D0274 LIMITED TO ONE UNIT PER 180 DAYS FOR ANY PROVIDER.
273	769	PSYCHIATRIC SERVICES ARE LIMITED TO 200 DOLLARS PER DAY PER CLIENT
182	770	CHIROPRACTOR CAN ONLY BE ATTENDING ON HCFA

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
119	771	PREFABRICATED CROWNS LIMITED TO 1 PER TOOTH/2 YEARS, ANY PROVIDER
3	772	CLAIM PAYMENT REDUCED BY REQUIRED VHAP CO-PAY.
96	773	DDMHS PARTIAL HOSPITALIZATION NOT ALLOWED SAME DAY AS OTHER DDMHS SERVICES
96	774	DENTAL PROCEDURES D5212 AND D5214 CANNOT BE BILLED TOGETHER ON THE SAME DATE
198	775	CHIROPRACTOR CANNOT BE ATTENDING ON UB92 OR PRESCRIBING ON PHARMACY
96	776	PAYMENT FOR SURGERY INCLUDES RELATED POST-OP VISITS (FED.GLOBAL SURGERY POLICY)
16	777	DENIED SERVICE, PLEASE SEE HEADER EOB INFORMATION
96	778	DENTAL PROCEDURES D5730 AND D5750 CANNOT BE BILLED TOGETHER ON THE SAME DATE
96	779	BOTH THE PANEL AND ITS COMPONENT CODES CANNOT BE BILLED FOR THE SAME DOS.
96	780	DENTAL PROCEDURES D5740 AND D5760 CANNOT BE BILLED TOGETHER ON THE SAME DATE
198	781	UNITS BILLED ON CLAIM EXCEED UNITS AUTHORIZED ON PRIOR AUTHORIZATION
16	782	RECIPIENT ELIGIBLE FOR PHARMACY/CROSS-OVER SERVICES ONLY
119	783	ENTERAL SUPPLIES (B9998) ARE LIMITED TO A MAXIMUM OF \$220 PER CALENDAR MONTH
204	784	THIS SERVICE IS NON-COVERED FOR PROGRAM BENEFICIARY IS ENROLLED IN
204	785	INPATIENT SERVICES NON-COVERED FOR VHAP LIMITED RECIPIENTS.
204	786	NURSING HOME SERVICES NON-COVERED FOR VHAP LIMITED SERVICES.
204	787	THIS SERVICE IS NON-COVERED FOR VHAP LIMITED RECIPIENTS.
204	788	OTC SERVICES NON-COVERED FOR VHAPRX AND VHAP LIMITED RECIPIENTS.
B15	789	CLIENT CANNOT RECEIVE BOTH OUTPATIENT AND RESIDENTIAL TREATMENT ON SAME DOS
35	790	THIS SERVICE/ITEM LIMITED TO ONCE PER BENEFICIARY LIFETIME.
24	791	HEALTHY VERMONTERS PHARMACY PROGRAM CLAIM
96	792	REFRACTION (92015) NOT COVERED FOR ADULTS PER 2002 LEGISLATIVE MANDATE

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
16	793	SAME X-RAY/INTERPRETATION ON SAME DAY REQUIRES DOCUMENTATION OF NECESSITY.
119	794	CAST MATERIALS/SUPPLIES ARE LIMITED TO ONE UNIT AND TYPE PER DOS.
1	795	RECIPIENT ENROLLED IN MCO. NONCOVERED AS FEE FOR SERVICE.
B7	796	PROVIDER TYPE INVALID FOR SUBMISSION OF ENCOUNTER CLAIMS FOR MCO RECIPIENTS.
190	797	DENIED. SERVICE INCLUDED IN MEDICAID REIMBURSEMENT FOR NURSING HOME STAY.
2	798	MEDICARE PART B CLAIM RECOUPED DUE TO INCORRECT PROCESSING ERROR.
97	799	CLAIM/DETAIL DENIED AS INCLUDED WITHIN A PREVIOUS BILLED SERVICE. PLEASE ADJUST.
16	800	MORE THAN ONE SURGERY, SAME DOS, REQUIRES ADMISSION HISTORY & PROCEDURE/OP NOTES
B20	801	ANOTHER PROVIDER HAS ALREADY BEEN PAID FOR THE SAME/SIMILAR SERVICE.
119	802	A MAXIMUM OF FIVE HOME VISITS PER MONTH ARE ALLOWED BY THE SAME PROVIDER
119	803	ONLY 5 OFFICE VISITS PER MONTH ARE PERMITTED FOR THE SAME PROVIDER
119	804	ONLY ONE HOSPITAL VISIT PER DAY IS ALLOWED FOR SIMILAR OR THE SAME DIAGNOSES
119	805	NURSING HOME VISITS ARE LIMITED TO FIVE PER MONTH
119	806	VITAMIN B12 INJECTIONS ARE LIMITED TO ONE PER MONTH
119	807	SPINAL ORTHOSES LIMITED TO 1 PER 365 DAYS
234	808	INJECTIONS SUCH AS 62310-19 & 01996 INCLUDED IN PAYMENT FOR GENERAL ANESTHESIA
273	809	CARE OF OCULAR PROSTHESIS (V2624) LIMITED TO TWICE PER EYE PER YEAR (365 DAYS).
97	810	INCLUDED WITHIN OR IDENTICAL TO A CONCURRENTLY BILLED SERVICE.
119	811	AMBULANCE TRIPS LIMITED TO ONE UNIT PER DAY PER PROVIDER
16	812	DDMHS GROUP THERAPY SESSIONS MUST LAST A MINIMUM OF 1 HOUR (UNITS=4)
119	813	DISCHARGE DAY MANAGEMENT LIMITED TO ONE PER HOSPITAL STAY PER RECIPIENT.
119	814	CHEMOTHERAPY TREATMENT IS LIMITED TO ONE UNIT PER DAY AND 4 UNITS PER WEEK.

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
273	815	DIAGNOSIS AND EVALUATION LIMITED TO 4 HOURS/MONTH OR \$192/MONTH PER RECIPIENT
119	816	GROUP THERAPY IS LIMITED TO 40 UNITS (10 HOURS) PER WEEK.
119	817	PSYCHOTHERAPY IS LIMITED TO FIVE HOURS PER WEEK
119	818	DAY ACTIVITY IS LIMITED TO FIVE PER WEEK.
B15	819	CODE CANNOT BE PAID UNLESS PRIMARY SURGERY IS AUTHORIZED+CODE IS SUBSTANTIATED
96	820	THIS PSYCHOLOGICAL/PSYCHIATRIC PROC.MAY ONLY BE BILLED IN ONE UNIT OF SERVICE.
273	821	PSYCHOTHERAPY PYMTS. APPROACHING MAX. ALLOWED. IF EXTENSION NEEDED, APPLY NOW.
16	822	RECIPIENT CANNOT BE CLASSIFIED AS BOTH MH AND MR/DD FOR THE SAME DATE OF SERVICE
119	823	MAXIMUM OF \$500 PER YEAR LIMIT HAS BEEN REACHED.
119	824	PSYCHOLOGICAL TESTING (90830/96100) IS LIMITED TO 5 HOURS PER YEAR (365 DAYS).
151	825	PAYMENT REDUCED TO MAXIMUM ALLOWED FOR TOTAL OB CARE.
151	826	PAYMENT REDUCED DUE TO DENTAL MAXIMUM ALLOWED AMOUNT FOR THIS RECIPIENT
119	827	ADULT DENTAL'S MAXIMUM ALLOWED AMOUNT HAS BEEN REACHED FOR THIS RECIPIENT
119	828	PROCEDURES W9184 AND 90830 LIMITED TO 5 HOURS A YEAR.
B13	829	TOTAL OB CARE CANNOT BE BILLED BECAUSE PRENATAL VISITS ALREADY PAID.
119	830	PRENATAL VISITS AND TOTAL OB CARE CANNOT BE BILLED FOR THE SAME PREGNANCY
B13	831	TOTAL OB CARE CANNOT BE PAID BECAUSE PARTIAL OB CARE ALREADY PAID
16	832	FOR FOLLOW UP INPATIENT CONSULTATIONS USE THE APPROPRIATE SUBSEQUENT CARE CODE.
16	833	AMBULANCE CERTIFICATION FORM MISSING
96	834	AN MD PROVIDING ACTUAL TREATMENT CANNOT ALSO BILL AS A CONSULTANT
16	835	PLEASE RESUBMIT WITH NOTES INDICATING DATE AND PROVIDER OF ORIGINAL SURGERY
97	836	POST-OP CARE IS INCLUDED WITHIN THE SURGICAL SERVICE REIMBURSEMENT

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
16	837	NEW PATIENT PROCEDURE CODES ARE NOT ALLOWED FOR ESTABLISHED PATIENTS.
B13	838	ROUTINE MAMMOGRAPHY SCREENING (76092) FOR BCCT CLIENT WAS PAID BY DOH
16	839	SUBSEQUENT CONSULT FOR RELATED CONDITION: USE ESTAB.PATIENT MEDICAL CODE
16	840	PLEASE RESUBMIT WITH COPIES OF THE APPROPRIATE INITIAL CONSULTATION RECORDS
97	841	CAST APPLICATION INCLUDED IN PRICE PAID FOR FRACTURE WITH REDUCTION FOR 30 DAYS
272	842	OBSERVATION ROOM VISITS AND ER VISITS CANNOT BOTH BE BILLED FOR THE SAME DOS.
119	843	PRENATAL VISITS LIMITED TO 15 PER YEAR
119	844	INITIAL CONSULTS ARE LIMITED TO ONE PER PATIENT FOR SIMILAR DIAGNOSES
97	845	THESE SERVICES INCLUDED IN PREVIOUSLY PAID ECG WITH STRESS TESTING
150	846	MORE THAN 1 ADMISSION TO SAME FACILITY WITHIN 30 DAYS NEEDS REVIEW OF ADMISSION HISTORIES
119	847	WEEKLY RADIATION THERAPY MANAGEMENT (77420-77430) IS LIMITED TO 5 UNITS PER WEEK
119	848	ADMISSION CODES LIMITED TO ONE PER PROVIDER SPECIALTY PER DOS
35	849	PA REQUIRED FOR MORE THAN TWO CONTACT LENSES PER LIFETIME
35	850	ONE INTRAOCULAR LENS ALLOWED PER LIFETIME.
119	851	THE MAXIMUM UNITS FOR REHAB EVALUATIVE SERVICES HAS BEEN MET FOR CALENDAR YEAR
16	852	GASTROSTOMY JEJUNOSTOMY TUBES B4086 ARE LIMITED TO TWO PER 6 MONTHS
119	853	SKILLED NURSING AND INTERMEDIATE CARE FACILITY VISITS ARE LIMITED TO ONE/WEEK
119	854	PRENATAL VISITS LIMITED TO 15/YEAR FOR NURSE MIDWIVES
234	855	INDIVIDUAL SERVICES AND WAIVER CANNOT BE BILLED FOR OVERLAPPING DATES
16	856	FOR SUBSEQUENT DAYS USE SUBSEQUENT HOSPITAL CARE CODES
49	857	SERVICE INCLUDED WITHIN ROUTINE NEWBORN CARE (99431).
272	858	PROCEDURE CODES W1000 AND A9030 CANNOT BE BILLED ON THE SAME DATE OF SERVICE

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
119	859	ROUTINE NEWBORN CARE LIMITED TO 1 PER DELIVERY
119	860	NEWBORN RESUSCITATION LIMITED TO ONE PER DELIVERY
166	861	THIS HUD/HHS IS NO LONGER A COVERED SERVICE
119	862	DENTURE ADJUSTMENTS ARE LIMITED TO ONCE PER DENTURE WITHIN 180 DAYS.
273	863	DAILY ESRD-RELATED SERVICES CANNOT PAY MORE PER CALENDAR MONTH THAN MONTHLY SVCS
16	864	PLEASE RESUBMIT WITH COPIES OF ALL ADMISSION HISTORIES WITHIN 30 DAYS.
B14	865	ONLY ONE OFFICE/EPSTDT VISIT PERMITTED PER DAY FOR SAME RECIPIENT, SAME PROVIDER
119	866	PAYMENT HAS BEEN MADE FOR MAXIMUM # ALLOWED. DVHA AUTHORIZATION NEEDED FOR MORE.
119	867	HEMODIALYSIS CODES 90935 AND/OR 90937 LIMITED TO 3 UNITS WITHIN 7 DAYS.
96	868	P.A. APPROVED FOR PURCHASE NOT RENTAL, REBILL WITHOUT MODIFIERS.
119	869	DDMHS "PARTIAL HOSPITALIZATION" (Z--50) IS LIMITED TO ONE PER DATE OF SERVICE.
119	870	MAXIMUM # OF ALLOWED UNITS HAS BEEN MET (W9173 LTD TO 60 UNITS/ CALENDAR YEAR)
96	871	ALLERGY VACCINES MAY ONLY BE BILLED IN 30 UNITS PER DATE OF SERVICE
96	872	OSTEOPATHIC MANIPULATIVE TREATMENT CANNOT BE BILLED IN ADDITION TO MEDICAL VISIT
16	873	INFORMATION ON ATTACHMENT IS OUTDATED. RESUBMIT WITH CURRENT INFORMATION.
119	874	REFILL TOO SOON.
119	875	PAYMENT REDUCED TO PSYCHOTHERAPY LIMITATION OF 8 UNITS PER DAY
96	876	CANNOT BILL NORMAL NEWBORN ADMIT AND SUBSEQUENT HOSPITAL VISITS FOR SAME STAY
119	877	PROCEDURE CODES X2800-X2809 LIMITED TO TWO UNITS PER DAY
119	878	GENERAL PSYCHOTHERAPY IS LIMITED TO 8 UNITS PER DAY.
119	879	DMH GENERAL PSYCHOTHERAPY (X2871,ETC.AND X4871,ETC.) LIMITED TO 28 UNITS/WEEK
B14	880	CONSULTATIONS LIMITED TO ONE UNIT PER DOS
119	881	90801 LIMITED TO 40 UNITS PER CALENDAR YEAR

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
96	882	DMH DAY HOSPITAL (X2876,X2876FB AND X2876TF) LIMITED TO ONE UNIT PER DAY
96	883	MH DAY TREATMENT (Z1035, Z2035, Z3035, Z5035) IS LIMITED TO ONE UNIT PER DAY
96	884	SERVICE NOT COVERED FOR CLIENT UNDER 18 YEARS ON DOS
119	885	MR MILEAGE (X3800-X3810) LIMITED TO 2 UNITS PER DAY
96	886	WHEELCHAIR REPAIRS INCLUDED IN WARRANTY FOR FIRST 12 MONTHS. CLAIM DENIED.
119	887	ECHOCARDIOGRAPHY LIMITED TO ONE PER DATE OF SERVICE.
119	888	MR/REHAB GENERAL PSYCHOTHERAPY IS LIMITED TO 28 UNITS (7 HOURS) PER WEEK
16	889	OFF-THE-SHELF SPLINTS ARE TO BE BILLED WITH PROCEDURE CODE A4570 AND AN INVOICE.
119	890	MR/REHAB DIAGNOSIS&EVAL.IS LIMITED TO 120 UNITS (30 HOURS) PER YEAR
119	891	OADAP DIAGNOSIS AND EVALUATION (X9004) LIMITED TO 20 UNITS (5HRS) PER 365 DAYS
216	892	PHARMACIST INTERVENTION DENIED BY CONSULTANT REVIEW.
16	893	SPAN OF DAYS FOR MILEAGE DOES NOT EQUAL DATES OF CLINIC VISITS.
B15	894	VHAP RX BENEFICIARIES REQUIRE REFRACTION CODE 92015 SAME DAY AS E & M
119	895	ADAP SUBSTANCE ABUSE CASE MANAGEMENT (H0006) LTD.TO 30 HRS (120 UNITS)/CAL.YEAR
119	896	WAIVER SERVICES LIMITED TO ONE UNIT PER DOS
119	897	THE MAXIMUM LABOR TIME ALLOWED FOR SEATING SYSTEMS IS 5 HOURS (20 UNITS)
119	898	THE MAXIMUM LABOR TIME ALLOWED FOR SEATING SYSTEM MODIFICATIONS IS 3 HOURS (12U)
119	899	DDMHS ADAP SERVICES Z0700, Z0737 & Z0738 ARE LIMITED TO 40 UNITS (10 HRS) PER WK
119	900	ROUTINE VENIPUNCTURE FOR SPECIMEN(S) COLLECTION LIMITED TO 1 UNIT/DAY/PROVIDER
177	901	CAPITATION CLAIM RECOUPED PER DVHA- RECIPIENT NOT ENROLLED IN MCO.
16	902	ANNUAL PCP PAYMENT IS LIMITED TO ONCE PER CALENDAR YR/PRIMARY PROVIDER
154	903	THE AMOUNT OF MEDICATION BEING BILLED EXCEEDS AMOUNT ORDERED BY PHYSICIAN.

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
24	904	ZERO PAID CLAIMS - DENTAL CLINIC PROCESSING.
119	905	DVHA PAYMENT FOR GLUCOMETERS IS LIMITED TO ONE PER PATIENT PER 5 YEARS.
96	906	WAIVER CODES X8100-X8122 CANNOT BE BILLED WITH PROCEDURE CODES X3800-X3888
96	907	ITEM IS NOT USUAL/CUSTOMARY FOR DIAGNOSIS/CONDITION INDICATED. PLEASE EXPLAIN.
16	908	NDC/MEDICATION BILLED DOES NOT MATCH MEDICATION/DESCRIPTION ON MD'S ORDER
97	909	THE MOTHER'S ADMISSION IS INCLUDED WITHIN THE OB/DELIVERY REIMBURSEMENT
119	910	VISUAL ANALYSIS AND INTERIM VISIT LIMITED TO ONE PER TWO YEARS
119	911	INTERIM VISUAL ANALYSIS LTD TO 1 PER 2 YEARS
16	912	MOST FRACTURES HEAL IN 6-8 WEEKS. WHY IS THIRD MONTH RENTAL MEDICALLY NECESSARY?
119	913	OPHTHALMOLOGICAL EXAM LIMITED TO 1/2 YEARS
35	914	THE MAXIMUM ALLOWED OF 3 ROOT CANALS PER ADULT RECIPIENT LIFETIME HAS BEEN MET
8	915	MISSING/INVALID NCPDP DATA ELEMENT
119	916	DMH/MR SPECIAL.GROUP REHAB LTD.TO 8 UNITS OR 2 HRS PER DOS
119	917	AS OF 1/1/96, DMH/MR SPECIAL.GROUP REHAB (Z**38) LTD.TO 40 UNITS (10 HRS)/CAL.WK
119	918	AMBULATORY SURGICAL CENTER FACILITY FEES ARE LIMITED TO ONE PER DOS.
4	919	AMBULATORY SURGICAL CENTERS: BILL MODIFIER SG ON YOUR PRIMARY SURGICAL PROC CODE
96	920	PROPHY.D1110, D1120 AND FULL MOUTH DEBRIDEMENT D4355 CANNOT BE PAID SAME DOS.
16	921	RESUBMIT WITH SPECIFIC INFORMATION ON PATIENT'S FUNCTIONAL LIMITATIONS
16	922	NEED DOCUMENTATION THAT USE OF A LESS EXPENSIVE ITEM WAS NOT ADEQUATE.
50	923	CLAIM RECOUPED PER REQUEST OF DVHA/PRO, DUE TO NON-MEDICALLY NECESSARY DAYS.
252	924	THIS CLAIM HAS BEEN RECOUPED. YOU MAY NOW SUBMIT A NEW CLAIM WITH MEDICARE EOMB
119	925	DMH EMERGENCY CARE IS LIMITED TO 28 UNITS (7 HOURS) PER DAY.

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
119	926	DMH EMERGENCY CARE IS LIMITED TO 140 UNITS (35 HOURS) PER WEEK.
16	927	RESUBMIT WITH ALL ATTACHMENTS REQUIRED FOR MANUAL PRICING.
119	928	RURAL HEALTH CLINIC AND FQHC ENCOUNTERS LIMITED TO 5 PER MONTH
119	929	Z5036 IS LIMITED TO 20 UNITS (5 HOURS) PER DAY & 100 UNITS (25 HOURS) PER WEEK.
16	930	RESUBMIT WITH EXPLANATION OF CONTINUED USE PAST USUAL LENGTH OF NEED
119	931	ORAL HYGIENE INSTRUCTIONS (01330) ARE LIMITED TO ONCE PER YEAR (365 DAYS)
119	932	CEPHALOMETRIC X-RAY (00340) IS LIMITED TO ONCE IN TWO YEARS.
119	933	DIAGNOSTIC MODELS (00470) ARE LIMITED TO ONE PER TWO YEARS.
119	934	DIAGNOSTIC PHOTOGRAPHS (00471) LIMITED TO ONCE IN TWO YEARS.
119	935	FULL MOUTH DEBRIDEMENT (D4355) IS LIMITED TO ONCE IN TWO YEARS (730 DAYS).
119	936	FLUORIDE TREATMENT IS LIMITED TO ONCE PER PATIENT PER 6 MONTHS.
97	937	IV FLUIDS USED TO MIX/ADMINISTER/FLUSH MEDS ARE INCLUDED IN IV INFUSION TX CODES
119	938	OCCLUSAL ORTHOTIC APPLIANCE LTD 1/365 DAYS
96	939	MILEAGE IS COVERED ONLY WHEN CLINIC,CASE MANAGEMENT OR REHAB SVCS.ARE PROVIDED
119	940	INITIAL ORAL EXAM D0150 LIMITED TO 1 PER PROVIDER PER 3 YEARS
119	941	PERIODIC ORAL EXAM (PROCEDURE D0120) LIMITED TO ONE PER SIX MONTHS.
119	942	ONLY ONE ORAL EXAM (INITIAL AND/OR PERIODIC) IS COVERED PER 6 MONTHS
119	943	COMPLETE SERIES RADIOGRAPHS LIMITED TO ONCE IN 6 MONTHS
96	944	INTRAORAL FILMS (00220 AND 00230) ARE LIMITED TO A MAX OF \$55 PER DOS, PER PROV.
94	945	BILLED AMOUNT ON CLAIM DOES NOT MATCH THE DOLLAR AMOUNT YOU REQUESTED ON YOUR PA
96	946	BILL DME SUPPLY CODES ONLY ONCE PER CALENDAR MONTH FOR TOTAL NUMBER OF UNITS.
119	947	PANORAMIC FILM LIMITED TO 1 PER 6 MONTHS
119	948	DENTAL PROPHYLAXIS (D1110, D1120, D4910) LIMITED TO 1 PER 6 MONTHS (180 DAYS)

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
119	949	PIN FOR RESTORATION (D2951) LIMITED TO ONE/TOOTH/YEAR,ANY PROVIDER
108	950	DME CANNOT BE RENTED FOR LONGER THAN 3 MONTHS UNLESS APPROVAL GIVEN BY THE DVHA.
16	951	BOTH THE DATE OF PRESCRIPTION AND THE DATE OF PROVIDER'S SIGN. NEEDED TO PROCESS.
16	952	PLEASE RESUBMIT ON DME/SUPPLIES CLAIM FORM
119	953	DENTURE REPAIRS ARE LIMITED TO ONCE PER DENTURE PER 180 DAYS.
119	954	DENTAL TISSUE CONDITIONING IS LIMITED TO ONCE PER DENTURE IN 2 YEARS (730 DAYS).
119	955	RESTORATIVE TREATMENT LIMITED TO ONCE PER TOOTH/TOOTH SURFACE PER YEAR.
B22	956	DIAGNOSES DO NOT JUSTIFY ITEM/SERVICE PROVIDED AND/OR FUNCTIONAL LEVEL.
97	957	DENIED.FIRST MONTH'S 'TENS' SUPPLIES INCLUDED IN RENTAL FEE FOR E0730-RR.
16	958	RESUBMIT WITH DATE ITEM PURCHASED (OR RENTAL START DATE) AND PROVIDER OF ITEM.
8	959	ENTERAL SUPPLIES ARE LIMITED TO HIGH TECH PROVIDERS,WITH PA FROM MEDICAID
16	960	RESUBMIT WITH YOUR LABOR RATE (PER HOUR) AND THE TOTAL TIME BEING BILLED.
16	961	PLEASE RESUBMIT UNITS SHOULD EQUAL NO. OF TOTAL ITEMS IN ALL INDIVIDUAL PACKAGES
197	962	DVHA AUTHORIZATION REQUIRED WHEN SERVICE PROVIDED TO BENEFICIARY UNDER AGE 18
16	963	ITEMIZE CHARGES FOR INDIVIDUAL ITEMS: NAME, COST OF EACH AND NUMBER SUPPLIED.
16	964	RESUBMIT WITH INVOICE AND COPY OF WARRENTTEE
4	965	INAPPROPRIATE CODE. PLEASE REFER TO YOUR HCPCS MANUAL.
16	966	SERVICE DATE IS BEFORE AUTHORIZED DATE IN PA NUMBER.
16	967	BILLED UNITS MUST = CHARTED TIME ONLY. 1U=15MINS. DO NOT INCLUDE THE BASE UNITS.
50	968	MEDICAL NECESSITY FORM DOES NOT DOCUMENT NEED OF ITEM
96	969	QUANTITY PROVIDED MONTHLY EXCEEDS NORMAL USAGE
16	970	PLEASE GIVE ITEMIZED LIST OF LABOR AND/OR PARTS CHARGES

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
97	971	THESE SUPPLIES ARE INCLUDED WITHIN THE REIMBURSEMENT OF THE EQUIPMENT RENTAL.
16	972	WHEELCHAIR PRICING REQUIRES BRAND NAME AND MODEL NUMBER
16	973	LENGTH OF NEED INDICATED ON THE MED.NECESSITY FORM CONTRADICTS BILLING RENTAL.
16	974	COMPLETE MED SUPPLIES SECTION OF MED. NEC. FORM AND INDICATE AVG. MONTHLY USAGE.
16	975	PLEASE RESUBMIT WITH MANUFACTUROR'S INVOICE OR SUGGESTED LIST PRICE
119	976	QUANTITY PROVIDED EXCEEDS ALLOWED/NORMAL AMOUNTS.
16	977	THE DATE THAT THE PHYSICIAN'S CERTIFICATION WAS COMPLETED IS ILLEGIBLE/INVALID.
108	978	INDICATED LONG TERM NEED (PER DIAGNOSIS OR >3 MOS) CONTRADICTS BILLING OF RENTAL
94	979	QUANTITY/UNITS BILLED EXCEED(S) AMOUNT APPROVED ON MEDICAL NECESSITY FORM
197	980	P.A. OR EXPLANATION REQUIRED TO JUSTIFY EXCESSIVE QUANTITIES/ UNITS.
108	981	DOCUMENTATION INDICATES TEMPORARY NEED. REBILL FOR RENTAL INSTEAD OF PURCHASE.
119	982	PERIODIC (ANNUAL) EXAM LIMITED TO ONCE PER YEAR.
96	983	SERVICE COVERED UNDER SOLE-SOURCE RESPIRATORY CONTRACT THROUGH DOS 06/30/01.
171	984	ONLY SOLE-SOURCE CONTRACTOR ALLOWED OXYGEN IN NURSING HOME (POS 31,32 & 33)
16	985	ATTACHED RX IS INCOMPLETE AND/OR DOES NOT COVER SOME OR ALL BILLED DATES
119	986	DENTAL SEALANTS (D1351 & D1352) LTD.TO ONCE/TOOTH PER FIVE YEARS, ANY PROVIDER.
16	987	Y9873 NEEDS MD PRESCRIPTION (DOSAGE, FREQ., DURATION) AND NATIONAL DRUG CODE #
16	988	EXPLANATION/DOCUMENTATION NEEDED TO JUSTIFY MORE EXPENSIVE ITEM
96	989	THERAPEUTIC FOSTER CARE (-TF) AND FAMILY BASED (-FB) SERVICES ARE EXCLUSIVE
16	990	DOCUMENTATION DOES NOT JUSTIFY NEED FOR STERILE ITEM(S)
16	991	SPECIFIC INFORMATION NEEDED TO EXPLAIN WHAT THE BILLED ITEM IS BEING USED FOR.

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
B12	992	CLAIM RECOUPED. GAINWELL WILL RESUBMIT NEW CLAIM WITH ORIGINAL EOMB AND ADJTM EOMB.
252	993	CLAIM RECOUPED. RESUBMIT NEW CLAIM WITH ORIGINAL EOMB AND MEDICARE ADJMT EOMB.
B12	994	AS REQUESTED THIS CLAIM HAS BEEN RECOUPED AND YOU MAY NOW RESUBMIT A NEW CLAIM.
B12	995	THIS CLAIM HAS BEEN RECOUPED PER PROV. NEW CLAIM HAS BEEN SUBMITTED FOR PROCESS
B12	996	THIS CLAIM IS RECOUPED BECAUSE OF PROCESSING ERROR, CLAIM WAS RESUBMITTED BY GAINWELL
B12	997	WE HAVE SPLIT AND REBATCHED YOUR CLAIM. IT WILL SHOW AS PENDING ON YOUR NEXT RA.
B12	998	THIS CLAIM WAS RECOUPED DUE TO AN ADJUSTMENT REQUEST SUBMITTED BY GAINWELL/DVHA
55	999	THIS CLAIM HAS BEEN RECOUPED DUE TO AN ADJUSTMENT REQUEST SUBMITTED BY PROVIDER.
16	1000	OCCURRENCE/ACCIDENT DATE IS AFTER THE FROM DATE OF SERVICE
16	1001	COPAY REIMBURSED FOR CAPITATED SERVICES ONLY
151	1002	MANUALLY PRICED UP TO THE ALLOWED NUMBER OF UNITS
16	1003	HOSPICE INPATIENT SERVICES EXCEED INPATIENT STAY
97	1004	A PORTION OF THIS CLAIM WAS PAID AS A HOSPICE CLAIM
4	1005	RESUBMIT WITHOUT A MODIFIER 76/77 AND WITH NOTES OF EXPLANATION
16	1006	SPLIT THE CLAIM ACCORDING TO AUTHORIZATION FOR HCBS OR ERC AND NURSING HOME
16	1007	THIS ADJUSTMENT IS A RESULT OF POST PAYMENT REVIEW DONE BY SUR UNIT
A1	1008	SERVICES NOT COVERED BY MEDICAID. RECIPIENT PARTICIPATING IN PACE
59	1009	CLAIM ADJUSTED/CUTBACK DUE TO MULTIPLE SURGERY POLICY
150	1010	MORE THAN ONE TIER FOR SAME OR OVERLAPPING DOS NOT ALLOWED FOR ERC.
16	1011	ATTACHED RA IS NOT LEGIBLE
B12	1012	THIS CLAIM HAS BEEN RECOUPED AS THE RESULT OF AN ADJUSTMENT REQUEST
142	1013	TBI SERVICE REDUCED BY PATIENT SHARE AMOUNT
50	1014	HPV VACCINE LIMITED TO 3 PER PATIENT PER LIFETIME

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
96	1015	PROGRAM COVERS COINS/DED ON DME DIABETIC SUPPLIES/J CODES SUBMITTED BY PHYSICIAN ONLY
16	1016	AS OF 1/1/07 WHEN BILLING 3 FILMS APPROPRIATE CODE IS D0273
16	1017	MAKE CORRECTIONS BASED ON HEADER OR DETAIL EOB DENIALS AND RESUBMIT NEW CLAIM
16	1018	BILLING PROVIDER NUMBER IS NOT CORRECT FOR UB92 YF FACILITY SERVICE
16	1019	BILLING PROVIDER NUMBER IS NOT CORRECT FOR HCFA LF NON-FACILITY SERVICE
96	1020	THE YOU FIRST PROGRAM DOES NOT COVER MALE BENEFICIARIES
12	1021	YOU FIRST PROGRAM DOES NOT COVER THIS DIAGNOSIS CODE
96	1022	YOU FIRST SERVICE COVERED FOR AGE 40 AND OVER ONLY
119	1023	SERVICE EXCEEDS YOU FIRST CVD SCREENING LIMIT OF 2 PER 310 DAYS
119	1024	HOME VISITS LIMITED TO 5 PER MONTH
96	1025	THIS SERVICE IS NOT COVERED UNDER THE YOU FIRST PROGRAM
96	1026	THIS REVENUE CODE IS NOT COVERED FOR THE YOU FIRST PROGRAM
96	1027	EITHER THE BILLING OR ATTENDING PROVIDER IS NOT ENROLLED IN THE YOU FIRST PROGRAM
96	1028	THIS CLAIM TYPE IS NOT COVERED BY THE YOU FIRST PROGRAM
252	1029	THIS YOU FIRST PROGRAM REQUIRES A VOUCHER FOR THIS SERVICE
119	1030	HBK AND F SERVICES EXCEED UNITS ALLOWED IN 12 MONTH PERIOD WITHOUT PA
149	1031	HBK AND F SERVICES HAVE EXCEEDED THE UNITS ALLOWED PER LIFETIME WITHOUT PA
199	1032	THIS REVENUE CODE REQUIRES A HCPCS/CPT CODE FOR THE YOU FIRST PROGRAM
23	1033	SPLIT CLAIM INTO SINGLE DETAIL CLAIMS WITH CORRECT OTHER INSURANCE FOR EACH DETAIL
96	1034	EITHER THE BILLING PROVIDER OR THE CLIENT IS NOT COVERED BY YOU FIRST PROGRAM
16	1035	MUST BE BILLED AS NDC TO PHARMACY
96	1036	THIS YOU FIRST DIAGNOSIS CODE IS BILLABLE ONLY FOR WOMEN AGE 40 AND OLDER
23	1037	THIS CLAIM TYPE REQUIRES OTHER INSURANCE PAYMENT SUBMITTED AT DETAIL LEVEL
151	1038	PAYMENT REDUCED TO PROVIDER MODERATE CAP BALANCE
119	1039	THIS PROVIDER'S MODERATE CARE ANNUAL CAP PAYMENT HAS BEEN MET

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
29	1040	RA INVALID DOCUMENTATION FOR TIMELY FILING. PREVIOUS DENIAL WAS FOR TIMELY FILING.
96	1041	SERVICES FOR MODERATE INDIVIDUALS ARE LIMITED TO REV CODE 070, 095, AND 096
16	1042	THIS SERVICE REQUIRES AN ITEMIZED BILL SENT TO YOU FIRST AT DEPT OF HEALTH
16	1043	SEND A CLINICAL REPORT TO YOU FIRST AT VDH FOR REVIEW PRIOR TO PAYMENT
A1	1044	THIS PROGRAM COVERS PART B DRUGS AND DIABETIC SUPPLIES ONLY ON THIS CLAIM TYPE
16	1045	SEND CLINICAL REPORT TO YF AT VDH TO CLARIFY SERVICES AS MULTIPLE ICD CM CODES WERE USED
119	1046	CASE MANAGEMENT BY HHA IS LIMITED TO 48 HOURS PER YEAR
119	1047	MODERATE SVCS FOR REV CODE 095 ARE LIMITED TO 30 HOURS PER MONTH
119	1048	MODERATE SVCS FOR REV CODE 096 ARE LIMITED TO 934 UNITS/MONTH
96	1049	VT MEDICAID DOES NOT COVER THIS SERVICE WHEN BILLED ON AN OUTPATIENT CLAIM
96	1050	DRUG SCREENINGS CANNOT REIMBURSED IF BILLED SAME DAY/SAME PROVIDER AS 82570/83986
250	1051	THE INFORMATION ON THE ATTACHED RA DOES NOT MATCH THE INFORMATION ON THE CLAIM
16	1052	RESUBMIT YOUR CLAIM WITH A COPY OF THE ORIGINAL RA THAT SHOWS PROOF OF TIMELY FILING
96	1053	THIS SERVICE IS NOT COVERED FOR THE PROGRAM THAT THE CLIENT IS ENROLLED IN
16	1054	THIS REVENUE CODE REQUIRES A CPT OR HCPCS CODE
96	1055	THIS SERVICE IS NOT VALID FOR THE DATE OF SERVICE BILLED
16	1056	THIS MODIFIER IS NOT VALID FOR THE DOS BILLED
16	1057	YOUR ELECTRONIC CERT FORM IS MISSING OR MISSING INFORMATION
119	1058	90846 IS LIMITED TO 12 PER YEAR
16	1059	DATE OF SERVICE ON THE CLAIM DOESN'T MATCH THE DATE OF SERVICE ON THE VOUCHER
16	1060	PROVIDER NUMBER ON YOUR CLAIM DOESN'T MATCH THE PROVIDER NUMBER ON THE VOUCHER
147	1061	THERE IS NO ANNUAL WAIVER MODERATE CAP AMOUNT ON FILE FOR THIS PROVIDER

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
16	1062	PLEASE INDICATE NURSING HOME NAME IN THE REMARKS FIELD
4	1063	MODIFIER NOT ACCEPTED AT THIS TIME. ALL MODIFERS ARE UNDER REVIEW BY DVHA.
29	1064	ONLY THE RA WITH PAID OR DENIED CLAIMS ARE ACCEPTABLE AS PROOF OF TIMELY FILING
29	1065	REQUEST FOR OVERRIDE OF TIMELY FILING HAS BEEN DENIED BY DVHA
16	1066	ONE OF THE DIAGNOSIS CODES BILLED IS NOT VALID PER ICD-CM LISTING
16	1067	THE FIELD 24E ONLY ACCEPTS DIAGNOSIS POINTERS1,2,3 OR 4 NOT THE ACTUAL DIAGNOSIS CODE
16	1068	ONE OF THE DIAGNOSIS BILLED IS NOT CONSISTENT WITH THE RECIPIENTS AGE
16	1069	PLEASE UNDERLINE OR CIRCLE UNITS OR TIMES ON ATTACHMENTS, DO NOT HIGHLIGHT OR WHITE OUT
119	1070	METHADONE TREATMENT LIMITED TO 1 PER CALENDAR WEEK
146	1071	ONE OF THE DIAGNOSIS CODES POINTED TO IS MISSING
16	1072	PROCEDURE DENIED AS COSMETIC. RESUBMIT WITH DOCUMENTATION PROVING MEDICAL NECESSITY
18	1073	THIS SERVICE HAS ALREADY BEEN FORWARDED TO ADMINISTRATIVE SERVICES FOR PAYMENT
96	1074	THIS CLIENT CANNOT HAVE BOTH HCBS AND FLEXIBLE CHOICES SERVICES ON THE SAME DATE
31	1075	PLEASE VERIFY BENEFICIARY UNIQUE ID - NUMBER NOT ON FILE WITH YOU FIRST
29	1076	ELEC ADJUSTMENT NOT ALLOWED. NOT ALL DETAILS MEET TIMELY FILING POLICY
140	1077	RECIPIENT NAME/NUMBER IS INCORRECT OR MISSING
16	1078	ORDERING PHYSICIAN NUMBER OR QUALIFIER IS MISSING OR NOT VALID
96	1079	ORAL HYGIENE INSTRUCTIONS D1330 CANNOT BE BILLED ON SAME DOS AS D0145
119	1080	ALLOWED ONLY ONCE PER DOS, ANY TOOTH
119	1081	G9003/G9007 LIMITED TO ONCE PER PATIENT PER YEAR
160	1082	NPI AND TAXONOMY COMBINATION INVALID FOR THIS CLAIM TYPE
8	1083	ITEM COVERED AS PHARMACY BENEFIT ONLY AND MUST BE BILLED BY PHARMACY. PA REQUIRED.
119	1084	OSTOMY RING LIMITED TO 30 PER 2 MONTH PERIOD
234	1085	CLAIM DENIED AS THE CLIENT HAS NO AUTHORIZATION FOR THIS WAIVER SERVICE.

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
97	1086	REIMBURSEMENT FOR ALL CHARGES INCLUDED IN DRG PAYMENT
96	1087	SERVICE NON COVERED FOR CHAP BENEFICIARY LIMITED TO PREMIUM ASSISTANCE ONLY.
96	1088	VERIFY RPL. OUR FILES SHOW HCBS SERVICES AUTHORIZED NOT NURSING HOME
16	1089	A CPT CODE IS REQUIRED AT DETAIL WHEN REVENUE CODE 360, 361, 362, 367 OR 490 IS BILLED
96	1090	ESI BENEFICIARY IS COVERED FOR CHRONIC CARE SERVICES ONLY
35	1091	E0243 LIMITED TO 1 PER RECIPIENT PER LIFETIME
119	1092	E8000-E8002 LIMITED TO 1 PER 3 YEARS
135	1093	INTERIM BILL NOT ALLOWED. RECOUP ORIGINAL CLAIM AND RESUBMIT ALL CHARGES TOGETHER.
96	1094	MOM AND BABY SERVICES CANNOT BE BILLED ON SAME CLAIM FOR DRG PRICING
4	1095	PROCEDURE/MODIFIER COMBINATION IS NON-REIMBURSABLE
119	1096	E AND M LIMITED TO 3 PER PREGNANCY PER PREGNANCY DIAG
16	1097	NDC IS REQUIRED AND NOT SUBMITTED OR NOT ON FILE
211	1098	SERVICE DENIED. MANUFACTURER IS NOT COVERED BY A REBATE.
96	1099	CLAIM DENIED WHILE WAITING PRICING FROM DVHA
242	1100	NO RECIPIENT RATE ON FILE
133	1101	CLAIM FORWARDED TO THE OOH FOR REVIEW. PRICING AND PMT BY ADMIN SVCS.
35	1102	SITZ BATH CHAIR LTD TO ONCE PER LIFETIME
35	1103	SPOT CHECK OXIMETER RENTAL LTD TO 3 MO/LIFETIME
35	1104	CONTINUOUS W/24HR TRENDING OXIMETER RENTAL LTD 6MO/LIFE
133	1105	THERE IS NO VALID GA VOUCHER FOR THIS SERVICE
206	1106	NPI REQUIRED FOR BILLING PROVIDER
206	1107	NPI REQUIRED FOR ATTENDING/RENDERING PROVIDER
208	1108	ATTENDING PROVIDER NPI NOT ON FILE WITH VT MEDICAID. CONTACT PROVIDER ENROLLMENT.
208	1109	BILLING PROVIDER NPI NOT ON FILE WITH VT MEDICAID. CONTACT PROVIDER ENROLLMENT.
197	1110	PLEASE REQUEST A RETROSPECTIVE PA FROM DVHA
96	1111	PAID DATE BEFORE DATE OF SERVICE
206	1112	NPI REQUIRED FOR REFERRING PROVIDER

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
208	1113	REFERRING PROVIDER NPI NOT ON FILE WITH VT MEDICAID. CONTACT PROVIDER ENROLLMENT.
16	1114	UNIT/UNIT OF MEASURE REQUIRED FOR NDC'S
16	1115	NDC MUST BE ENTERED IN FIELD 24D
107	1116	CLAIM WAS UNABLE TO BE PRICED. PRICING DETAIL IS IN DENIED STATUS.
151	1117	INDIVIDUAL ALLOWANCE REDUCED TO NOT EXCEED CLAIM TOTAL BILLED
70	1118	ADDITIONAL OUTLIER PAYMENT
143	1119	PAYMENT REDUCED DUE TO PARTIAL ELIGIBILITY
97	1120	CLAIM PAYMENT REDUCED, DOLLARS ARE INCLUDED IN THE CASE RATE
96	1121	THIS SERVICE IS NOT COVERED FOR THE CASH AND COUNSELING PROGRAM
119	1122	CLAIM PAYMENT REDUCED TO RECIPIENTS FLEXIBLE CHOICES QUARTERLY ALLOTMENT AMT
199	1123	REV CODE 071 LIMITED TO HCPCS T1019, T2025, S5121, AND S5199 FOR CASH AND COUNSELING PROGR
119	1124	RECIPIENT'S FLEXIBLE CHOICES QUARTERLY ALLOTMENT AMOUNT HAS BEEN MET
1	1125	VHAP BENEFICIARY HAS ALREADY BEEN PAID FOR 60 DAYS OF NH SERVICES FOR THIS CALENDAR YEAR
97	1126	PAYMENT FOR THIS DETAIL IS INCLUDED IN PAYMENT FOR PRIMARY PROCEDURE
16	1127	ADMISSION DATE MUST BE EQUAL TO HEADER FROM DATE OF SERVICE
16	1128	NDC, UNITS AND UNITS MEASURE NOT IN CORRECT ORDER. PLEASE CORRECT AND RESUBMIT
16	1129	ADMISSION AND FROM DATE DO NOT MATCH
280	1130	DRUG CROSSOVER CLAIMS MUST BE SUBMITTED DIRECTLY TO CHANGE HEALTH CARE
16	1131	OCCURRENCE CODE BILLED IS NOT VALID FOR REHABILITATIVE THERAPY SUBMITTED
16	1132	OCCURRENCE CODE AND THERAPY START DATE MUST BE BILLED WHEN SERVICE IS REHAB THERAPY
18	1133	OUR HISTORY FILES SHOW THIS SERVICE HAS BEEN REIMBURSED BY PBM
119	1134	CUSHION LIMITED TO 1 PER 365 DAYS
50	1135	DVHA HAS REVIEWED AND DENIED YOUR APPEAL REQUEST
35	1136	PROCEDURE LIMITED TO ONCE PER TOOTH PER LIFETIME
22	1137	PROVIDER MUST APPEAL OTHER INSURANCE AND BISHCA
151	1138	MAX ALLOWED AMOUNT FOR OB SERVICES HAS BEEN MET

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
108	1139	RENTAL ONLY ALLOWED FOR 1 MONTH. AFTER THAT ITEM MUST BE PURCHASED
119	1140	PURCHASE LTD 1 IN 5 YEARS
108	1141	PREVIOUS RENTAL PRICE INCLUDED IN PAYMENT FOR PUCHASE
211	1142	SERVICE DENIED, ONE OF THE MANUFACTURES IS NOT COVERED BY A REBATE
119	1143	OPHTHALMOLOGIC EXAM LIMITED TO 1 IN 2 YEARS
119	1144	ALVEOLOPLASTY LTD TO 4 QUADRANTS PER 365 DAYS
151	1145	MEDICAID RATE DECREASED BY 2 PCNT PER THE FY 2010 BUDGET ACT PASSED BY THE LEGISLATURE
96	1146	THIS PROGAM COVERS DIABETIC SUPPLIES, J CODES FOR MAINTENANCE DRUG COINS/DED ONLY
16	1147	RECIPIENT HAS MEDICARE PART C. PLEASE BILL THEIR SELECTED CARRIER
B13	1148	ALREADY PAID BY YOU FIRST THROUGH VDH. QUESTIONS CALL YF BILLING LINE AT 800-508-2222
107	1149	THIS SERVICE DENIED AS NO ABN PAP RESULT ON FILE YOU FIRST
119	1150	OXIMETER PURCHASE LTD TO 1 PER 5 YEARS PER BENEFICIARY
16	1151	TOTAL CHARGE MISSING, OR DOES NOT EQUAL THE SUM OF INDIVIDUAL CHARGES
29	1152	INVOICE/MSRP MUST BE WITHIN 1 YEAR FROM DATE OF SERVICE
16	1153	ATTACHMENT FROM A NON-SECURE WEBSITE IS NOT ACCEPTABLE
16	1154	NDC IS NOT VALID FOR HCPCS CODE BILLED
163	1155	PLEASE USE THE MEDICARE ATTACHMENT SUMMARY FORM
163	1156	THE OI AMOUNT IN PRIOR PAYMENTS FIELD DOES NOT MATCH OI PAYMENT ON ATTACHMENT
251	1157	ATTACHED DOCUMENTATION IS ILLEGIBLE
B12	1158	SERVICE PROCESSED BY THE FITP PROGRAM.
B12	1159	SERVICE PROCESSED BY THE CSHN PROGRAM.
96	1160	CSHN NOT COVERED OVER THE AGE OF 21.
96	1161	CSHN NON-COVERED SERVICE
96	1162	FITP NON-COVERED SERVICE
197	1163	CSHN SERVICE REQUIRES PRIOR AUTHORIZATION
109	1164	FITP/CSHN SERVICE PRIOR TO 01/01/2010, PLEASE BILL FITP OR CSHN DIRECTLY.
96	1165	FITP NON-COVERED SERVICE RECIP OVER AGE 3
96	1166	SERVICE NOT COVERED BY MEDICAID/DR. D/VHAP/OTHER PROGRAMS

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
197	1167	FITP SERVICE REQUIRES PRIOR AUTHORIZATION
177	1168	CSHN ELIGIBILITY IS INCOMPLETE
197	1169	FITP OR CSHN SERVICE REQUIRES PRIOR AUTHORIZATION
97	1170	MULTI FUNDED CLAIM - PLEASE REBILL WITH EACH DETAIL ON ITS OWN CLAIM
152	1171	SERVICE LIMITED TO 1 HOUR PER DATE OF SERVICE FOR FITP AND CSHN PROGRAMS
151	1172	MEETINGS LIMITED TO 6 UNITS PER YEAR
242	1173	THERAPY ASSISTANT NOT COVERED BY MEDICAID PROGRAM
242	1174	REGISTERED DIETICIAN CANNOT BE BILLING PROV FOR MEDICAID PROGRAM.
B12	1175	SERVICE PROCESSED BY THE YOU FIRST PROGRAM.
16	1176	D1351 U9 ONLY COVERS TEETH A,J,K,T,4,5,12,13,20,21,28 OR 29
177	1177	FITP ELIGIBILITY IS INCOMPLETE
242	1178	FITP CSHN SVS ON HOME HEALTH CANNOT INCLUDE DETAIL PROCEDURE CODE, BILL JUST REV CODE
119	1179	PERSONAL CARE SERVICES LIMITED TO 1 PER DAY
149	1180	LIMITATION FOR THIS SERVICE HAS BEEN MET
119	1181	T2023 LIMITED TO 1 PER MONTH
119	1182	LIMITED TO ONE PER MONTH
119	1183	J7303 LIMITED TO 18 UNITS PER 365 DAYS
119	1184	LIMIT 96 UNITS PER DAY - ONE UNIT EQUALS 15 MINUTES
119	1185	REPLACEMENT OF REUSABLE EXTERNAL RECEIVER/MONITOR LIMITED TO ONE PER 730 DAYS / 2 YEARS
119	1186	95249 / 95250 / 95251 LIMITED TO ONCE PER 30 DAYS
119	1187	LIMITED TO TWO PER 6 MONTHS
96	1188	95249, 95250 AND 95251 LIMITED TO A MAXIMUM OF 4 TIMES PER CALENDAR YEAR
119	1189	A4456 IS LIMITED TO 50 PER 31 DAYS
23	1190	FITP TPL OVERRIDE ACCEPTED
200	1191	PAPER CROSSOVER SUBMITTED BEFORE 30 DAYS FROM MCR PAID DATE
119	1192	MULTIPLE-DENSITY INSERTS LIMITED TO 2 PER FOOT PER 365 DAYS
16	1193	RURAL HEALTH/FQHC PROVIDERS MUST BILL SVCS AND T1015
226	1194	PLEASE PROVIDE DOCUMENTATION TO SUPPORT CHANGES ON RESUBMITTED CLAIM

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
198	1195	REVENUE CODE ON YOUR CLAIM DOES NOT MATCH THE REVENUE CODE ON THE PA
151	1196	UNITS MUST MATCH DATE SPAN
198	1197	CODE/MODIFIER ON CLAIM DOESN'T MATCH PA. SEND CHANGE-REQUEST INFORMATION TO PA ISSUER
16	1198	USE MORE SPECIFIC DIAGNOSIS CODE FOR STERILIZATION PROCEDURE
119	1199	UNITS EXCEED YEARLY ALLOWED. PA NOT ISSUED OR DOES NOT MATCH CLAIM.
31	1201	USE BENEFICIARY UNIQUE ID INSTEAD OF SSN
119	1202	COUNSELING VISITS LIMITED TO 16 PER CALENDAR YEAR
16	1203	PA NOT ON FILE OR CLAIM DOES NOT MATCH PA
204	1204	THE CODE BILLED IS NOT REIMBURSABLE BY MEDICAID AT THIS TIME
119	1206	92608 IS LIMITED TO 10 UNITS PER 365 DAYS WITHOUT PA
119	1207	92607 IS LIMITED TO 1 UNIT PER 365 DAYS WITHOUT PRIOR AUTHORIZATION
97	1208	CIS SERVICES MAY NOT BE BILLED INDIVIDUALLY AND BUNDLED IN SAME MONTH
18	1209	EITHER BASE CODE OR BASE CODE WITH GT MODIFIER ALLOWED PER DAY
119	1210	EXCEED LIMIT 1 UNIT OF A4604 OR A7037 REIMBURSED PER 90 DAYS
119	1211	EXCEED LIMIT 1 UNIT OF A7027 OR A7030 REIMBURSED PER 90 DAYS
119	1212	EXCEED LIMIT 1 UNIT OF A7029 OR A7033 REIMBURSED PER 30 DAYS
119	1213	EXCEED LIMIT 2 UNITS OF A7028 REIMBURSED PER 30 DAYS
119	1214	EXCEED LIMIT 1 UNIT OF A7031 REIMBURSED PER 30 DAYS
119	1215	EXCEED LIMIT 2 UNITS OF A7032 REIMBURSED PER 30 DAYS
119	1216	EXCEED LIMIT 1 UNIT OF A7034 REIMBURSED PER 90 DAYS
119	1217	EXCEED LIMIT 1 UNIT A7035 REIMBURSED PER 180 DAYS
119	1218	EXCEED LIMIT 1 UNIT A7036 REIMBURSED PER 180 DAYS
119	1219	EXCEED LIMIT 2 UNITS A7038 REIMBURSED PER 30 DAYS
119	1220	EXCEED LIMIT 1 UNIT A7046 REIMBURSED PER 180 DAYS
119	1221	EXCEED LIMIT 1 UNIT A7039 REIMBURSED PER 180 DAYS
119	1222	EXCEED LIMIT 1 UNIT A7044 REIMBURSED PER 180 DAYS
119	1223	EXCEED LIMIT 1 UNIT A7045 REIMBURSED PER 180 DAYS
119	1224	PAYMENT REDUCED DUE TO INAPPROPRIATE BILLING OF COMPLEXITY LEVEL
96	1225	DETAIL DENIED. SEE DETAIL FOR REASON
119	1226	FITP/CSHN SCREENING LIMITED TO 1 PER YEAR PER PROVIDER

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
16	1227	PLEASE INDICATE OTHER INSURANCE PAYMENT AMOUNT ON THE MEDICARE ATTACHMENT SUMMARY FORM
4	1228	THIS PROCEDURE CODE REQUIRES MODIFIER LT OR RT
251	1229	MEDICARE ATTACHMENT SUMMARY FORM IS INCOMPLETE
198	1230	PRIOR AUTHORIZATION TYPE DOES NOT MATCH PROGRAM IN WHICH RECIPIENT IS ENROLLED
4	1231	THIS CODE IS COVERED FOR RENTAL ONLY AND REQUIRES THE RR MODIFIER.
119	1232	PARTIAL HOSPITALIZATION CODES G0410/G0411 ARE LIMITED TO 7 UNITS PER DAY
16	1233	BILL RANGE OF DATES AND ONE UNIT
16	1234	PLEASE RESUBMIT WITH VACCINE SPECIFIC DIAGNOSIS
119	1235	RENTAL OF E2402 IS LIMITED TO 1 PER MONTH
119	1236	A6550 LIMITED TO 15 UNITS PER MONTH
119	1237	A7000 LIMITED TO 10 UNITS PER MONTH
119	1238	NURSING HOME SERVICE PRICED AT 30 DAYS PER EPISODE - VHAP RECIPIENT
16	1239	THE AMOUNT IN THE BOX 54 ON YOUR CLAIM IS INCORRECT.
251	1240	BLANKET DENIAL IS MISSING THE PROVIDER SIGNATURE AND/OR DATE SIGNED
B15	1241	PAYMENT ADJUSTED DUE TO MULTIPLE SURGERY GUIDELINES
16	1242	CLAIM ALIGNMENT ISSUE- PLEASE CORRECT AND RESUBMIT
119	1243	99408, 99409, G0396, G0397 LTD TO 1 PER 365 DAYS
16	1244	INCLUDE CONTRACTUAL ALLOWANCE ON OI PAYMENT AMOUNT
16	1245	PLEASE SUBMIT CURRENT VERSION OF CONSENT FORM
119	1246	J7307 LIMITED TO ONCE PER THREE YEARS
B12	1247	LEVEL I PSYCH PER DIEM
4	1248	PA ON FILE FOR THIS SVC DOES NOT HAVE A MODIFIER AND CANT BE PROCESSED. PLEASE CORRECT
197	1249	THIS SERVICE REQUIRES PA BECAUSE 8 VISITS HAVE ALREADY BEEN PAID
B12	1250	PAYMENT AUTHORIZED DUE TO MEDICARE RECOUPMENT
B12	1251	PAYMENT AUTHORIZED DUE TO CBA RECOUPMENT
16	1252	CLAIMS INVOLVING CLINICAL TRIALS MUST ALSO GIVE THE RELATED CANCER DIAGNOSIS
16	1253	SUBMIT CLAIM AND ATTACHMENTS TO DVHA ATTN DENTAL APPEALS

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
16	1254	SUBMIT TPL CHANGE REQUESTS TO THE ADDRESS OR FAX NUMBER LOCATED ON THE TPL CHANGE R
119	1255	V5266 HEARING AID BATTERIES LTD TO 24 PER 30 DAYS
119	1256	GO476 LTD TO 1 UNIT PER 5 YEARS
16	1257	PROCEDURE CODE REQUIRED WITH THIS REVENUE CODE FOR EVV
223	1300	PROCEDURE IDENTIFIED AS PRIMARY IN NCCI CODE PAIRS
223	1301	UNABLE TO ELECTRONICALLY ADJUST PRIMARY CCI PROCEDURE. PLEASE SUBMIT PAPER ADJ REQ.
236	1302	SERVICE DENIED, NOT PAYABLE UNDER NCCI REGULATIONS
273	1303	DETAIL DENIED. UNITS EXCEED NCCI MAXIMUMS.
97	1309	ZERO PAYMENT - SERVICE BUNDLED
96	1310	ZERO PAYMENT - REPORTING SERVICE ONLY
146	1311	PRIMARY DIAGNOSIS BILLED NOT ALLOWED AS PRIMARY
22	1408	OTHER INSURANCE DENIAL CODE IS MISSING/NOT ACCEPTED. REBILL WITH A COPY OF PAYMENT/DENIAL
96	1410	90801 AND 90801-GT ARE NOT REIMBURSED ON THE SAME DAY FOR SAME RECIPIENT
96	1411	90804 AND 90804-GT ARE NOT REIMBURSED ON THE SAME DAY
96	1412	90806 AND 90806-GT ARE NOT REIMBURSED ON THE SAME DAY
96	1413	90808 AND 90808-GT ARE NOT REIMBRUSED ON THE SAME DAY
96	1414	90805 AND 90805-GT ARE NOT REIMBURSED ON THE SAME DAY
96	1415	90807 AND 90807-GT ARE NOT REIMBURSED ON THE SAME DAY
96	1416	90809 AND 90809-GT ARE NOT REIMBURSED ON THE SAME DAY
96	1417	90846 AND 90846-GT ARE NOT REIMBURSED ON THE SAME DAY
96	1418	90847 AND 90847-GT ARE NOT REIMBURSED ON THE SAME DAY
96	1419	90853 AND 90853-GT ARE NOT REIMBURSED ON THE SAME DAY
96	1420	90862 AND 90862-GT ARE NOT REIMBURSED ON THE SAME DAY
16	1421	ANESTHESIA CODES USE 15 MINUTE UNITS FOR DOS PRIOR TO 01/01/12
16	1422	PLEASE BILL MEDICARE HOSPICE FIRST AND ATTACH A COPY OF PAYMENT OR DENIAL.
16	1423	THIS CODE USES 15 MINUTE UNITS
B15	1424	ADMINISTRATION ONLY PAID WHEN VACCINE BILLED ON SAME DOS
B13	1425	PROCEDURE CODE HAS ALREADY BEEN PAID FOR SAME DATE AND SAME DIAGNOSIS
96	1426	REPAIR OF FRAME/LENSES CAN NOT BILLED ON SAME DATE AS NEW GLASSES

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
182	1427	PLEASE REBILL WITH EXPLANATION OF MODIFIER AM
96	1429	T1019 AND T1020 WITH OR WITHOUT MODIFIERS CANNOT BE BILLED ON SAME DOS
16	1430	SUBMIT DOCUMENTATION THAT SHOWS MORE THAN ONE VACCINE FOR THIS DX
197	1431	PRIOR AUTHORIZATION NECESSARY, SEE DMH FOR LEVEL I AUTHORIZATION
197	1432	DMH LEVEL I PRIOR AUTHORIZATION EFFECTIVE JULY 1, 2012
16	1433	PLEASE RESUBMIT WITH NOTES THAT INDICATE PROVIDER WAS A COSURGEON.
119	1434	T2025 LIMITED TO ONE PER MONTH
96	1435	G0101/Q0091 AND E/M CODES CAN/T BE BILLED ON SAME DOS
96	1436	DENIED DUE TO INAPPROPRIATE BILLING OF COMPLEXITY LEVEL
96	1437	ONLY SFI BUNDLED SERVICE CAN BE PAID FOR THE SAME DOS
16	1438	RESUBMIT WITH NOTES INDICATING GESTATION LENGTH FOR DOS
204	1439	BENEFICIARY IN LIMITED BENEFIT PROGRAM SRVS NOT COV
234	1440	INTEGRATED FAMILY SERVICES BUNDLE HAS BEEN BILLED
234	1441	INTEGRATED FAMILY SERVICES INDIVIDUAL BILLS HAVE BEEN REIMBURSED
16	1442	OTHER INSURANCE PYMT LESS THAN 3.00. RESUBMIT WITH INITIAL INSURANCE ATTACHMENT SHOWIN PYM
16	1443	REFERRING/ORDERING PROVIDER MUST BE AN INDIVIDUAL
119	1444	HEARING AIDS LIMITED 1 PER 3 YEARS
119	1445	PROC CODE V2784 IS LIMITED BASED ON BENE AGE ON DOS
147	1446	EPCP CLAIM
169	1447	IF MEDICARE DEDUCT OR COINS IS EQUAL OR MORE THAN BILLED AMOUNT, SEND MEDICARE EOMB
16	1448	EOMB NEEDED IN ADDITION TO MASF
96	1449	DO NOT ALLOW NON BUNDLE CODES IF BUNDLE OR MINI BUNDLE HAS BEEN BILLED
119	1450	ALLOW ONLT 1 UNIT OF SERVICE PER CALENDAR MONTH
96	1454	PROC CODE/MOD/SAME RECIP LIMITED BY PROVIDER
146	1455	DIAGNOSIS CODE VERSION INCORRECT FOR DOS
146	1456	SURGICAL PROCEDURE CODE VERSION INCORRECT FOR THE DOS
146	1457	IMPROPER ICD VERSION SUBMITTED ON PROF CLAIM
16	1458	PROC CODE/MOD/SAME RECIP LIMITED TO SPECIFIC PROVIDER
242	1459	PAY MAX DAYS ALLOWED ON PA OR WITH NO VALID PA

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
119	1460	DVHA ONLY COVERS EXTERNAL CEPHALIC VERSION ONCE PER PREGNANCY
97	1461	ORDERING PROVIDER NOT ACTIVE ON THE DATE OF SERVICE
35	1463	DVHA ONLY PAYS FOR ONE STERILIZATION PER RECIPIENT PER LIFETIME
16	1464	INAPPROPRIATE PCS. PLEASE REFER TO CURRENT ICD-PCS MANUAL
16	1465	CLAIMS INVOLVING CLINICAL TRIALS MUST GIVE THE RELATED CANCER DIAGNOSIS
16	1467	PRIMARY DX MUST BE FOR SUBPOPULATION REFUGEES
16	1468	REQUIRED NOTATION MISSING FROM CLAIM
119	1470	LIMIT OF 16MG PER DAY FOR BUP DRUGS
135	1471	ADMIT DATE EQUAL TO OR 1 DAY AFTER IP STAY
B15	1472	PAYMENT ADJUSTED DUE TO TRANSFER/SHORT STAY PRICING
119	1473	ONLY ONE UNIT OF ALCOHOL OR DRUG SERVICE PERMITTED PER DOS
119	1474	J7304 LTD TO 40 PER 365 DAYS
16	1475	USE APPROPRIATE NURSERY REVENUE CODES FOR ALL ROOM AND BOARD CHARGES
16	1476	V2784 WITH CORRESPONDING MODIFIERS MUST BE BILLED WITH V2100 -V2499
16	1478	DOS TOO FAR INTO THE FUTURE
16	1479	PLEASE RESUBMIT WITH APPROPRIATE FORM
160	1480	QUALIFIER IS MISSING AND IS REQUIRED OR INVALID
119	1481	AREA OF ORAL CAVITY MISSING OR INVALID
16	1482	ICD VERSION INDICATOR IS INVALID OR IS MISSING
119	1483	D0230 IS LIMITED TO 5 UNITS PER DOS
119	1484	G0424 LIMITED TO 2 SESSIONS PER DAY PER BENEFICIARY
119	1485	G0424 REQUIRES A PA FOR MORE THAN 36 SESSIONS PER BENEFICIARY
96	1486	G0424 IS NOT TO BE BILLED WITH OTHER THERAPEUTIC SERVICES ON THE SAME DOS
96	1487	ANESTHETIC MANAGEMENT LIMITED TO FOUR METHODS PER PATIENT FOR SAME DATE OF SERVICE
16	1488	DO NOT PUT TOTAL CHARGES ON UB CLAIM
96	1489	THIS CLAIM WAS GIVEN INDIVIDUAL CONSIDERATION BY OUR UR DEPARTMENT AND HAS BEEN DENIED
35	1490	D0393 LTD TO 2 PER PATIENT PER LIFETIME
16	1491	NDC UNITS MUST MATCH THE UNITS BILLED
16	1492	PROVIDER NOT AUTHORIZED TO BILL THAT MANY MG

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
16	1493	NOTE ENTERED DOES NOT MATCH NDC BILLED
96	1494	NOTE THE DATE MCR A EXHAUSTED/STARTED, SIGN AND DATE
16	1495	INVOICE ILLEGIBLE
206	1496	NPI REQUIRED FOR SUPERVISING PROVIDER
206	1497	NPI REQUIRED FOR ORDERING PROVIDER
234	1498	DETAIL PACKAGED DUE TO COMPOSITE PRICING
150	1499	CLAIM HAS BEEN PREVIOUSLY ADJUSTED SUBMIT ON PAPER
234	1500	DETAIL PACKAGED DUE TO COMPLEXITY PRICING
16	1501	WAITING PLACEMENT MUST BE BILLED
198	1502	PRIOR AUTHORIZATION DOES NOT COVER THE WHOLE STAY. CONTACT DVHA FOR PA ADJUSTMENT
181	1503	SEQUELEA CODE NOT ALLOWED AS PRIMARY
16	1504	DONOR NAME NOT LISTED ON CLAIM
119	1505	C9448 LIMITED TO 2 PER MONTH
119	1506	C9450 LIMITED TO 19 PER 2 YEARS
16	1507	PRIMARY DIAGNOSIS CODE MISSING
B15	1508	INCORRECT ADMINISTRATION CODE BILLED
89	1509	INCORRECT NUMBER OF COMPONENTS BILLED
29	1510	TIMELY FILING APPEAL LIST OF RECIPIENTS OR DOS MISSING
119	1511	SURGICAL BOOT/SHOE, EACH LIMITED 1 UNIT PER 365 DAYS
119	1513	COCHLEAR IMPLANT DEVICE ACCESSORIES LIMITED 2 PER YEAR
96	1514	L8627/ L8628 LTD TO 2 PER 3 YEARS
119	1515	L8621 LTD TO 420 UNITS PER YEAR
119	1516	L8614 LTD TO 1 SIDE EVERY 10 YEARS
119	1517	59430 LIMITED TO ONE PER YEAR
125	1518	SPAN OF DAYS REQUIRED
151	1520	COINSURANCE/DEDUCTIBLE IS MORE THAN THE TOTAL BILLED
146	1521	ICD-10 CODE NOT VALID BEFORE 10/01/2015
119	1522	G0249 LTD TO 1 UNIT PER 4 WEEKS
16	1523	D9310 NOT REIMBURSABLE ON SAME DOS AS ORAL EVALUATION
16	1524	ORIGINAL EOB REQUIRED
146	1525	PCS SURGICAL PROCEDURE CODE REQUIRED.
198	1526	REV CODES OR DAYS AUTHORIZED DO NOT MATCH
16	1527	0360T,0361T,0362T,0363T NOT ALLOWED ON SAME DOS AS ADAPTIVE BEHAVIOR CODES

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
151	1528	IF COINSURANCE MORE THAN 50 PERCENT OF BILLED AMOUNT SEND MEDICARE EOMB
96	1529	THE SURGICAL PROCEDURE CODE BILLED IS NON COVERED BY MEDICAID
251	1530	NO MEDICARE SEGMENT ON FILE FOR RECIPIENT FOR DOS ON THE CLAIM
16	1531	DATES ON MEDICARE SUMMARY FORM DO NOT MATCH DATES OF SERVICE ON FILE
4	1532	HD MODIFIER ALLOWED FOR FEMALES ONLY AGE 12-55
151	1533	COINSURANCE OR DEDUCTIBLE ON MASF DOES NOT MATCH MEDICARE EOMB
186	1534	REIMBURSEMENT REDUCED DUE TO DURATION OF CARE
96	1535	ONE OF DX BILLED IS NOT COVERED
B15	1536	OCCURRENCE SPAN DATE MISSING OR INVALID
B15	1537	VALUE CODE BILLED REQUIRES A VALUE AMOUNT
119	1538	DRUG TESTS LTD TO 8 PER MONTH
16	1539	AUTHORIZED DATES DO NOT MATCH DATES BILLED
119	1540	O359T LTD TO 1 PER 365 DAYS
29	1541	ADJUSTMENT DENIED MORE THAN 1 YEAR FROM ORIGINAL PAID DATE
16	1542	DETAIL CHARGES COVERED BY MEDICARE
119	1543	PAYMENT REDUCED TO MATCH AUTHORIZED DAYS
16	1544	INCORRECT HOSPICE ADMIT DATE
119	1545	A7020 LTD TO 1 UNIT EVERY 2 MONTHS
16	1546	MEDICAL NOTES DO NOT SUPPORT LEVEL/LENGTH OF CARE
132	1547	CLAIM IDENTIFIED AS EVV
119	1548	LIMIT 97803 AND 97804 TO 5 DAYS/CALENDAR YEAR
279	1550	INCONTINENCE SUPPLIES ONLY PAYABLE TO SINGLE VENDOR
16	1600	CLAIM DOES NOT HAVE VERIFIED SUPPORTING EVV VISIT
119	1874	GROUP THERAPY 90853 LTD TO 1 SESSION PER DAY
119	1877	GROUP THERAPY 90853 LIMITED TO 3 SESSIONS PER WEEK
119	1878	90853 GROUP THERAPY LIMITED TO A MAXIMUM OF 8 UNITS / 1 SESSION PER DAY PER RECIPIENT
16	1879	ATTENDING PROVIDER TAXONOMY IS INVALID.
223	1880	ADD-ON PROC NOT ALLOWED WHEN PRIMARY PROC NOT PRESENT
132	1881	PROCESSED AS AN ACO CLAIM
4	1882	MODIFIER 76 OR 77 NOT ALLOWED IF BASE CODE HAS NOT BEEN BILLED ALONE

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
4	1883	PROCEDURE CODE BILLED WITH 76 OR 77 MODIFIER ONLY ALLOWED TWICE PER DOS
198	1885	DIAGNOSIS ON THE CLAIM, NOT IN RANGE APPROVED ON THE PA
96	1886	PROCEDURE CODE/TOOTH NUMBER COMBINATION NOT ALLOWED
146	1888	ICD CODE OR VERSION IS INVALID OR MISSING
70	1890	HOSPICE SIA PAYMENT
119	1891	BENEFICIARY MAX MET FOR E0935
198	1892	THE CODE/MODIFIER BILLED MUST MATCH THE CODE/MODIFIER REQUESTED ON THE PA
16	1893	USE A CONDITION CODE TO INDICATE A DISTINCT VISIT
96	1894	D9110 NOT ALLOWED ON SAME DOS AS DENTAL
96	1895	D9110 NOT ALLOWED 10 DAYS FOLLOWING DENTAL
119	1896	D1352 LTD TO 1 PER YEAR
119	1897	D3221 LTD TO ONE TOOTH PER LIFETIME
16	1898	INITIAL ADMIN ALLOWED 1 PER DOS WITH APPROPRIATE UNITS
16	1899	ADDITIONAL ADMIN ALLOWED 1 PER DOS WITH APPROPRIATE UNITS
B2	1900	COVERAGE DUE TO COVID 19 PANDEMIC
96	1901	D3221 NOT ALLOWED ON SAME DOS AS D3230-D3330
119	1902	REPLACEMENT OF LOST OR BROKEN RETAINER LTD TO ONE PER ARCH PER PATIENT PER LIFETIME
16	1903	REVENUE CODE NOT CONSISTENT WITH PROCEDURE CODE BILLED
4	1904	MODIFIER NOT ALLOWED ON CLAIM TYPE
119	1905	OCCLUSAL GUARDS LTD TO 1 SET PER 2 YEARS
119	1906	BENEFIT MAX MET FOR H2000/HU
119	1907	THERAPEUTIC CODES LTD TO 4 UNITS PER DOS
16	1908	BENEFICIARY INELIGIBLE FOR SERVICE DUE TO NO LTC AUTHORIZATION ON FILE FOR DOS
26	1909	BENEFICIARY INELIGIBLE FOR SERVICE ON DOS DUE TO REVOKED HOSPICE ELECTION
16	1910	BILL ONLY THE LAST DOS AND ICD CODES
96	1911	H2022HE/HB NOT ALLOWED ON SAME DOS AS H2022HW
119	1912	SCALING AND DEBRIDEMENT LTD 1 PER 180 DAYS
119	1913	A4553 LTD TO 3 PER 180 DAYS
119	1914	A9285 LTD TWO PER FIVE YEARS
16	1915	SERVICE NOT COVERED FOR THIS DIAGNOSIS

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
16	1916	BILL ALL FIRST ADMINISTRATIONS PER DOS ON 1 DETAIL WITH SPECIFIC # OF UNITS
16	1917	BILL ALL ADDITIONAL ADMINISTRATIONS PER DOS ON 1 DETAIL WITH SPECIFIC # OF UNITS
119	1918	A4224 LTD TO 1 PER WEEK
97	1919	RE-EVAL AND EVAL NOT ALLOWED ON SAME DOS
96	1920	RE-EVAL AND EVAL ONLY ALLOWED ONE PER DOS
16	1921	L3257 MUST BE BILLED WITH SHOE CODE WITH LT AND RT
125	1923	A MORE SPECIFIC DX IS AVAILABLE FOR ONE OR MORE DX CODES
125	1924	A MORE SPECIFIC CODE IS AVAILABLE FOR ONE OR MORE SURGICAL PROC CODES
35	1925	REFUGEE VISITS LIMITED TO 2 PER LIFETIME
16	1926	REV CODE NOT COVERED FOR DOS BILLED
272	1927	MEMBER MUST ACCESS HOSPICE BENEFIT THROUGH MEDICARE
119	1928	ALLOWED BY VT MEDICAID PER PRIMARY INSURANCE RULES AND OI APPROVAL
119	1929	ITEM PREVIOUSLY PD IN FULL VIA RENTAL/PURCHASE
119	1930	PYMT REDUCED BY AMOUNT PAID FOR RENTAL OF THIS ITEM
16	1931	INVALID PROCEDURE CODE NDC COMBINATION BILLED
16	1932	RESUBMIT WITH MEDICAID WEB PRINTOUT RA
16	1933	RE-ADMISSION DAY SHOULD BE CODED USING SUBSEQUENT HOSPITAL CARE CODES
16	1934	REVIEW DX BILLED. IT DOES NOT APPEAR TO BE CORRECT. RESUBMIT AFTER CORRECTION
59	1935	SECONDARY SURGERY IS MANUALLY PRICED AT 30 PERCENT OF ALLOWED AMOUNT
59	1936	SECONDARY SURGERY IS MANUALLY PRICED AT 40 PERCENT OF ALLOWED AMOUNT
16	1937	REV CODE 199 CAN ONLY BE BILLED FOR PSYCH CLAIM
119	1938	MAX RENTAL/PURCHAS ALREADY EXISTS
251	1939	NOTES DO NOT SUPPORT DUPLICATE BILLING OF TRIPS
16	1940	TAXONOMY IS MISSING OR PROVIDER NUMBER NOT ON FILE
150	1941	1 ADMISSION/OBSERVATION ALLOWED PER 30 DAYS PER SPECIALTY
125	1942	DETAIL CPT/HCPCS CODE NOT VALID
119	1943	MAXIMUM UNITS HAVE ALREADY BEEN PAID FOR THIS SERVICE

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
16	1944	INCORRECT BILLING OF ADMIN CODE SEE PROVIDER MANUAL FOR CLARIFICATION
125	1945	AH OR AJ MODIFIER REQUIRED DEPENDING ON THE ATTENDING PROVIDER TYPE
96	1946	CODES CAN NOT BE BILLED WITHIN SAME CALENDAR MONTH
18	1947	DUPLICATE-A CROSSOVER CLAIM HAS BEEN PAID FOR DOS/PROV
16	1948	MEDICARE PART A EOB IS MISSING
22	1949	CARRIER CODE SUBMITTED ON CLAIM NOT VALID
16	1950	ORDERING PROVIDER CANNOT BE THE SAME AS ATTENDING OR BILLING PROVIDER
119	1951	PROCEDURE CODE IS LIMITED TO 8 PER DOS
119	1952	LIMITED TO 1 PER 9 MONTHS
119	1953	LIMITED TO 1 PER 3 YEARS
119	1954	LIMITED TO 1 PER CALENDAR YEAR
16	1955	FOLLOW INSTRUCTIONS FOR RAPID RE-ADMIT AND BILL THE CLAIM ACCORDINGLY
119	1956	LIMITED TO 1 PER 8 YEARS
116	1957	LIMITED TO 1 PER 5 YEARS
96	1958	CLINICAL REVIEW-CLAIM DOES NOT MATCH LEVEL OF CARE
119	1959	MULTIPLE SURGERY PRICE BASED ON UNITS BILLED
132	1960	PROCESSED AS NON-ACO PROVIDER
16	1961	PRIMARY DX MUST BE DEPENDENCE DX
169	1962	PROCESSED AS COST EFFECTIVE ALTERNATIVE
132	1963	PROCESSED AS AN ABA CASE RATE CLAIM
8	1964	PROVIDER TYPE AND SPECIALTY NOT CONSISTENT FOR ADD-ON CODE BILLED
16	1965	MEDICARE PART B EOB IS MISSING
16	1967	DME CLAIMS CAN NOT BE BILLED FOR DATE SPAN OF MORE THAN 3 CALENDAR MONTHS
132	1968	PROCESSED AS A DS ENCOUNTER CLAIM
197	1969	SERVICE NOT COVERED OR REQUIRES A PA/VOUCHER
16	1970	MSRP/RETAIL NOT ACCEPTED. PLEASE RESUBMIT WITH PURCHASE INVOICE.
16	1971	ITEM ON INVOICE DOES NOT MATCH ITEM ON CLAIM. PLEASE RESUBMIT WITH CORRECT INVOICE.
59	1972	PRICED BASED ON MULTIPLE SURGERY GUIDELINES

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
16	1973	INVOICE NOT ACCEPTED WITH REQUIRED INFORMATION BLACKED OUT OR MISSING. PLEASE RESUBMIT.
16	1974	CODE DESCRIPTION STATES 1 UNIT EQUALS 100 CALORIES. PLEASE RESUBMIT WITH CORRECTED UNITS.
16	1975	CODE DESCRIPTION STATES 1 UNIT EQUALS 500 ML. PLEASE RESUBMIT WITH CORRECTED UNITS.
119	1977	SERVICE LTD TO 3 PER CALENDAR YEAR
119	1978	SERVICE LTD TO 12 PER CALENDAR YEAR
169	1979	PROCESSED AS A CIS ZERO-PAY ENCOUNTER CLAIM
24	1980	MEDICAID CAP FUND PAYMENT - CIS
24	1981	STATE ONLY CAP FUND PAYMENT - CIS
16	1982	QUOTE NOT ACCEPTED. PLEASE RESUBMIT WITH PURCHASE INVOICE.
16	1983	CREDIT CARD STATEMENT NOT ACCEPTED. PLEASE RESUBMIT WITH PURCHASE INVOICE.
197	1984	SERVICE AUTHORIZATION REQUIRED FOR HIGH DOLLAR CLAIM
16	1985	SUBSEQUENT INTERIM BILLING CLAIMS REQUIRE VALUE CODE 75
16	1986	VALUE CODE 75 UNITS DO NOT MATCH PREVIOUS INTERIM BILLING CLAIMS
169	1987	99199 HW AND T2022 HW NOT ALLOWED ON SAME DAY
119	1988	SERVICE LTD TO 1 PER MONTH
119	1989	CIS CAP LIMIT MET
119	1990	PAYMENT REDUCED TO CIS MEDICAID CAP BALANCE
119	1991	PAYMENT REDUCED TO CIS STATE ONLY CAP BALANCE
16	1992	CODE NOT PAYABLE ON OUTPATIENT CLAIM TYPE
16	1993	CODE NOT PAYABLE ON PHYSICIAN CLAIM TYPE
132	1994	PROCESSED AS AN SMI WAIVER CLAIM
132	1995	PROCESSED AS AN SMI INVESTMENT CLAIM
132	1996	PROCESSED AS A SUD CLAIM
132	1997	PROCESSED AS A GC POPULATION CLAIM
132	1998	PROCESSED AS A ZERO PAY BR-APM CLAIM
16	1999	HCPCS HAS SPECIFIC CODE FOR ITEM. MISC/UNSPEC CODE NOT ACCEPTED. RESUBMIT W CORRECT CODE
169	2000	DMH ZERO PAY CASE LOAD QUALIFYING ENCOUNTER
234	2001	DMH ZERO PAY SUPPORTING ENCOUNTER
96	2002	BRATTLEBORO RETREAT INTERIM CLAIM NOT ALLOWED FOR NON-SMI CLIENT
119	2003	J7394 ALLOW ONCE PER YEAR

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
119	2004	J7295 ALLOW 13 PER YEAR
119	2005	ALLOW 1 PER 5 YEARS
109	2006	SUBMITTED PRIOR TO 100 DAYS LIMIT
23	2007	IVD COVERAGE REVIEWED
119	2008	ONLY ALLOWED 4 UNITS PER DOS
31	2009	RECIPIENT NUMBER IS NOT ON FILE OR MISSING FROM CLAIM
132	2010	ACO ZERO PAY - GLOBAL PAYMENT PROGRAM CLAIM
B15	2011	A9901 NOT ALLOWED TO BE BILLED WITHOUT E0627
16	2012	INAPPROPRIATE USE OF MODIFIER 25
119	2013	PSYCHOTHERAPY CODES LTD TO 260 UNITS PER CALENDAR YEAR
119	2014	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURANCE HAS BEEN REACHED.
119	2015	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURANCE HAS BEEN REACHED.
119	2016	LABOR TIME MUST BE REPORTED IN 15-MINUTE INCREMENTS
119	2017	LABOR TIME MUST BE REPORTED IN 15-MINUTE INCREMENTS
58	2018	PLACE OF SERVICE ON CLAIM DOESN'T MATCH PA
119	2022	A4224 LIMITED TO 5 UNIS PER 30 DAYS
B15	2023	VACCINE CODE ONLY PAYS WHEN ADMINISTRATION BILLED ON SAME DOS
119	2024	Q9992 LIMITED TO 1 UNIT PER MONTH - FOR 2 MONTHS THEN PA IS REQUIRED
119	2025	S0311 LIMITED TO 4 UNITS PER 120 DAYS
119	2026	90867 90868 AND 90869 LIMITED TO A MAXIMUM OF 36 UNITS COMBINED PER CALENDAR YEAR
169	8000	DETAIL ADDED
150	8001	DETAIL DENIED
59	8002	AMOUNT REDUCED - MULTIPLE SURGERY PROCEDURES
18	8003	RECOUP THE PREVIOUSLY PAID SURGERY AND BILL ALL SURGERIES ON SAME CLAIM
29	8004	TIMELY FILING APPROVAL SOF FOR EXTENUATING CIRCUMSTANCES
119	8005	1 OFFICE/PREV VISIT PER RECIP.PER DAY,SAME ATT
96	8006	NO MEDICARE-HOSPICE SEGMENT ON FILE
96	8007	MCR HOSPICE SEGMENT DOES NOT MATCH ADMIT DOS
96	8008	BENIFICARY HAS MCR HOSPICE ON DOS
234	8009	RADIOLOGY CUTBACK - CONTIGUOUS BODY PART
B10	8010	RADIOLOGY CUTBACK CONTIGUOUS BODY PART OUTPATIENT

Adjustment Reason Code	Medicaid EOB	EOB MESSAGE TEXT
59	8011	MULTIPLE SURGERY PROCEDURES - PROCEDURE NOT REIMBURSED
59	8012	MULTIPLE SURGERY PROCEDURES - PROCEDURE PAID AT 50 PERCENT
59	8013	MULTIPLE SURGERY PROCEDURES - PROCEDURE PAID AT 40 PERCENT
59	8014	MULTIPLE SURGERY PROCEDURES - PROCEDURE PAID AT 30 PERCENT
16	8015	PLEASE PROVIDE MASF AND EOB FOR CLAIMS SUBMITTED MORE THAN 2 YEARS FROM THE DOS
35	8016	81275/81276 LTD TO 1 PER LIFETIME
119	8017	A4670 ALLOWED 1 PER 5 YEARS
109	8018	PEDIATRIC PREVENTIVE SERVICES SUBMITTED BEFORE 90 DAYS FROM DOS
23	8019	PEDIATRIC PREVENTIVE SERVICES
234	8020	CLAIM CUTBACK DUE TO ULTRASOUND CONTIGUOUS BODY PART
35	8021	81265 LIMITED ONE UNIT PER LIFETIME
119	8022	97802 ALLOW 1 DAY PER CALENDAR YEAR
119	8024	LABOR TIME MUST BE REPORTED IN 15-MINUTE INCREMENTS
96	8025	CLAIM TYPE NOT ALLOWED FOR IHIP RECIPIENT
B7	8026	CLAIM DENIED, PLEASE SUBMIT WITH PROOF OF IBCLC CREDENTIALS
169	8100	PROCEDURE REPLACES SUBMITTED PROCEDURE - AGE CONFLICT
169	8101	PROCEDURE REPLACES SUBMITTED PROCEDURE - VISIT TYPE CONFLICT
169	8102	PROCEDURE REPLACES SUBMITTED PROCEDURE - REBUNDLE CONFLICT
169	8103	PROCEDURE REPLACES SUBMITTED PROCEDURE - GENDER CONFLICT
6	8104	PROCEDURE REPLACED FOR AGE CONFLICT
97	8105	PROCEDURE IS MUTUALLY EXCLUSIVE TO ANOTHER SUBMITTED PROCEDURE
169	8106	PROCEDURE REPLACED FOR VISIT TYPE CONFLICT
97	8107	PROCEDURE DENIED OR REPLACED - REBUNDLED INTO ANOTHER PROCEDURE
7	8108	PROCEDURE REPLACED FOR GENDER CONFLICT
16	8109	PROCEDURE DOES NOT WARRANT ASSISTANT SURGEON
54	8110	PROCEDURE DOES NOT WARRENT ASSISTANT SURGEON
97	8111	PROCEDURE IS INCIDENTAL TO ANOTHER SUBMITTED PROCEDURE
97	8112	PRE-OPERATIVE SERVICE NOT PAID DURING GLOBAL PERIOD
97	8113	POST-OPERATIVE SERVICE NOT PAID DURING GLOBAL PERIOD
B16	8114	NEW PATIENT PROCEDURE CODES ARE NOT ALLOWED FOR ESTABLISHED PATIENTS